CONCEPTS OF COMMUNITY IN MENTAL HEALTH 1935 TO 1965

A MODIFIED GROUNDED THEORY APPROACH USED WITH ORAL HISTORY AND OTHER SOURCES

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ABSTRACT

This research project explores the history of the theoretical conceptualisation of community in mental health during a watershed period between 1935 and 1965. St Crispin Hospital in Duston, Northampton provides a focus for the research. Mental health services between 1850 and 1965 are described, setting the work into historical context. Concepts of community that could apply to mental health are briefly reviewed. Previous studies have under-stated the degree of continuity between hospital and local community and have underplayed the importance of compulsory detention for concepts of community. The research uses an historical approach combining a modified grounded theory strategy with oral histories and other documentary sources. The research includes a description of how additional new buildings for "voluntary patients" and older asylum buildings became separated at St Crispin Hospital, in the psyches of staff and some in local communities. The internal patient labour economy operating in St Crispin Hospital is recorded as a new contribution to local history. Clear dividing lines between the mental hospital and the outside community "at the gate" are refuted with respect to St Crispin Hospital showing it to have had a mechanical solidarity with the local village. This is defined as the theoretical concept of a "geographic-occupational community". The concept of communities formed of members, by choice, and who have feelings of belonging, is rejected. This is considered as being inapplicable to mental health to the extent that coercion is a recognised means of admission. The fact that being in hospital may not always have been equated by patients with "bad" and outside as "good" is explored. Furthermore, being outside may not necessarily be equated with being "integrated" and inside as being "segregated". A wartime and post-war crisis in St Crispin Hospital and the manner in which reform was initiated demonstrates the importance of the leadership of charismatic and/or powerful individuals, nurses, doctors and others. The sometimes-important role of hospital-based volunteers in the initiation of change following the post-war crisis in St Crispin Hospital in Northampton is revealed. Neglect of these voluntary services in the literature, with a concentration on those voluntary initiatives based in the community, is identified. A second theoretical concept of the "community of interest" is developed as an analytical tool to understand the ways in which mental health patients became linked and even integrated within an "outside" community, which included volunteers, as the "geographic-occupational community" gradually broke down. A re-assessment of the importance of new medical treatments in the post war period suggests that new drugs and "open door" policies may have been mutually re-inforcing. A third theoretical concept of the "risk community" is developed as a tool to explore the growing emphasis on risk management. The nature of risk in mental health today is revealed as being perceived to be more widespread and to have become the primary mode of governance. Areas for further study are identified. These include: the use of the three theoretical concepts of community, developed in this project as analytical tools, in exploring mental health services of other times and places; further exploration of work carried out in mental hospitals by voluntary organisations; the contributions made by significant individuals in local services; and the exploration of patient labour working patterns in a wider range of hospitals. The project concludes by recognising the importance of finding research strategies to give a voice to the central characters in the story of mental health and community, namely the patients from St Crispin Hospital, whose accounts have been silenced through a combination of attrition and contemporary research governance frameworks.

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AUTHOR DECLARATION

During the period of registered study in which this dissertation was prepared, the author has not registered for any other academic award or qualification.

R. J. Griffin, August 2005.

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INTRODUCTION

This research project is focussed primarily on the history of a specific time and place, namely St Crispin Hospital in Duston, Northampton. The work follows an earlier research project in 1997 during which the oral history method was used with other sources in a small study of mental health nursing between 1940 and 1965. Indications were gained from that earlier study that such a history might throw light on not only the history of mental health services but also potentially expose the social processes of which it is a part. Included in this possibility is the potential to analyse the notion of the concept of "community" in mental health. The growth of the mental hospital system in Britain, particularly during the nineteenth century, brought together groups of individuals, patients, staff and others, within which complex cultural, social and economic interactions were established. The earlier research indicated inconsistencies in extant literature including with respect to the relationship between the old institution of St Crispin Hospital and the community local to it. This inconsistency provided the possibility of using a further study to re-think notions about theoretical concepts of community. This was felt to be of particular relevance at the current time when the word "community" is imbued with a quality that implies it is necessarily "good" without its meaning being easily defined.

Note: St Crispin Hospital was first named Northamptonshire County Lunatic Asylum when it opened in 1876. The name was changed subsequently to Berrywood Mental Hospital. For reasons of clarity and consistency, the name St Crispin Hospital, the last name by which it was known, will be used throughout this thesis.

The aims and objectives of the project will be explored next.

Aims.

The overall aim of this research has been to develop a critical investigation, using a number of sources including oral history testimony, and focussed primarily on St Crispin Hospital, of how concepts of "community" in mental health have evolved and been portrayed during the period from approximately 1935 to 1965. This thirty-year time-span was chosen for a focussed exploration as the research indicated it to have been a watershed period in the development of mental health services. It is demonstrated as a time during which changes from the localised, Victorian asylum system, began to break down to evolve into community based services. During the course of this investigation, the nature of the historic mental health community and its subsequent evolution into differing forms has been explored.

This period is of particular interest because it has been relatively under-explored in historical accounts of asylums and mental health care. The Nineteenth Century growth of the asylum system and the post-institution community care era have been well documented but the 1930s, 1940s and 1950s are crucial in laying the foundations for many of the therapeutic, policy and broader cultural understandings of mental health and how it should be dealt with.

Objectives of the Pilot Work.

Interim objectives of the pilot stages of this project were as follows:

- An exploration into the history of mental health and social policy in England and Wales. This review would begin earlier than the ultimate date range of this study

and explore a period from 1850 to 1965. The intention of starting at this earlier date was to enable the placing of the thirty-year period of the study (1935 to 1965) in a historical context. For example, the earlier period covered the main building phase of the asylum system.

- The exploration of extant literature and the results of previous research about different models and theoretical concepts relating to "community".
- The development of a suitable research model. This was developed with the use of a pilot study prior to the main project. Included in the pilot study was a re-analysis of interviews with retired mental nurses conducted for the earlier project, combined with one new interview.
- The exploration of different sources of data including archive material.

The main research study aims.

The aims of the main research project have been as follows:

- To determine what factors shaped concepts of the nature of community as related primarily to St Crispin Hospital between 1935 and 1965.
- To establish what concepts of community evolved during the period in question.
- To develop the research methodology further, making it inclusive of individuals who were staff, patients or members of populations associated with mental hospitals and in particular St Crispin Hospital during the period of exploration.
- To establish how cultural, economic, social, philosophical, technological and policy changes affected theoretical concepts of community, the pattern of provision and attitudes to those designated as mentally ill.

The main research study objectives.

The objectives of the research project have been as follows:

- To explore the history of theoretical concepts of "community" in the context of mental health provision using the period from 1935 to 1965 using St Crispin Hospital in Northampton as the main focus.
- To develop a multi-strategy methodology with a modified grounded theory approach using different sources, including those that originate from groups associated with mental hospitals, to give a "voice" to those historically involved.
- To use the research approach to develop original theoretical understandings of the origin and nature of concepts of community associated with mental health.

The background of the author is in mental health and a brief resume of his career will be presented next.

The background of the author in mental health.

The author worked as an ancillary for approximately two years at St Crispin Hospital. After becoming a Student Nurse in March 1972, he qualified as a Registered Mental Nurse under a General Nursing Council inspired experimental module scheme in November 1973. A "module" consisted of a ten-week experience. The first week involved a school based theoretical preparation for the speciality to be experienced, for example, rehabilitation, followed by an eight-week ward placement and then a school based week of consolidation. The scheme was intended to overcome the perceived division between school theory and ward practice.

After qualifying, the author worked first as a Junior Staff Nurse for one year and then, after registration, as a Staff Nurse until 1976. The author then left mental

health and worked at Kettering General Hospital where he trained as a Registered General Nurse, remaining for six months as a Staff Nurse in intensive and coronary care. Missing the experience of work in mental health, he then returned, spending approximately six months at St Andrew's Hospital in Northampton before returning to St Crispin for two further years as a Charge Nurse in acute admission. In 1980, the author left Northampton for the services in the north of Northamptonshire, latterly Rockingham Forest NHS Trust, first as a Community Psychiatric Nurse, then as the Clinical Nurse Specialist in acute admission and finally as Senior Clinical Nurse Manager for adult in-patient services in mental health. He retired in 1997 as a result of injury. The author remains a registered nurse, though is not currently practising.

The research process created something of a dilemma for the author who wrote as a historian while recording a past with which he was involved. On a personal basis, however, it made it possible for the author to contextualise his working life and better understand the processes he experienced. This has revealed the history of changing communities in mental health as more than a linear, deterministic process driven largely by policy change. Progress is shown as uneven and influenced also by individuals in a way that has sometimes been for the better and sometimes for the worse, as communities, and notions of community, have changed. In relation to the debate as to whether history is an art or a science, Jenkins (1991:56) argues that

> "...history is, in opposition to it being an art or a science, something else – something *sui generis*, a worldly, wordy language game played for real, and where the metaphors of history as science or history as art, reflect the distribution of power that put these metaphors into play."

The history of mental health services has largely been reflected in the accounts of the most powerful within the organisations, their written records and personal views.

Many academics have also used sources largely related to strategic initiatives. Jenkins (1991:18) however, asks the question as not "what is history?" but "who is history for?" and that history therefore becomes "problematic because it is a contested term/discourse, meaning different things to different groups".

This research project explores not divisions among major ideologies but focuses at a micro level on a particular place during a particular time-span, St Crispin Hospital in Northampton. It incorporates, along with other sources, testimony of some of the ordinary individuals who experienced changes in the nature of the mental health communities within which they were treated or worked. The author, as noted, was a member of such a work community and was aware, during the progress of this research project, of the influence of personal experiences and the need to stay true to the revelations within the data (some of which were sourced from ex-colleagues). The intention has been to give a voice to those directly participating "at the cutting edge" in the historical changes influencing the nature of the conceptualisations of community in mental health, in a particular place and at a particular time.

An outline of the dissertation.

The dissertation consists of eight chapters. The focus of each chapter is as follows:

Chapter One briefly describes mental health and social policy in England and Wales during a period from 1850 to 1965. The way in which mental illness has historically been conceptualised, as well as the nature of the relationship between the mentally ill and the communities from which inmates were drawn in this period, is discussed in this chapter. Provision for those designated mentally ill is also examined. This includes the integration of individuals within local rural communities, confinement

under the Poor Laws, institutionalisation under the Lunacy Acts and Mental Health Acts, and the development of medicalisation. Pressures against institutional confinement in the latter part of the twentieth century will also be considered.

Chapter Two is a brief review of literature relating to conceptualisations of the nature of community. The review examines what is understood by the term "community". It focuses on perceptions of community and the way these perceptions have been reflected in mental health provision, in the development of service structures, and wider social effects. The review proceeds from a historical perspective in examining theories of community. It indicates that simple notions of division between the core concepts of "hospital" and "community" within much of the mental health related policy literature are inadequate.

Chapter Three describes the theoretical basis of this research project into conceptualisations of community. The research exploration is noted as having been divided into two periods, 1935 to 1950 and 1950 to 1965 and a rationale for this is presented. Appropriate literature referring to both the theoretical underpinning and methodology of the research is critically appraised. The development of a pilot study and its outcomes are described. The research process for the main study, that includes a modified grounded theory approach using oral history combined with other sources, is outlined. The development of the research methodology is critically appraised in light of the research experience. A description of the structure and development of the research procedures is given, including the recruitment of subjects and methods adopted to gather, analyse and develop data. Also included are tactical refinements to the methodology adopted during the research process.

Chapter Four, the first of three results chapters, explores data in respect of the historical background of mental health services, primarily at St Crispin Hospital, in the period from the middle of the 1930s until approximately 1950. The data reveals the strongly hierarchical nature of the internal organisation of the mental hospital at this time. A new perspective in which St Crispin Hospital is regarded as more than a bounded community within the geographical environment of a surrounding village is revealed. The hospital as a "Geographic-occupational Community" is explored in respect of contributions to local work economies. Also considered in this chapter is data in respect of an emphasis in the recruitment of nurses with musical and sporting skills. This chapter also considers the nature of a gender divide within institutions. The possibility of the avoidance of recruitment from families living in the locality of St Crispin Hospital in this period is also examined. A crisis at St Crispin Hospital relating to care, resources and management revealed after the Second World War is described. The origins of change concurrent with the formation of the National Health Service are explored.

Chapter Five explores evidence revealed in relation to evolution in concepts of community within mental health during the period of approximately 1950 to 1965. It also explores some of the outcomes of these changes. Policy changes, initiatives by staff and volunteers, as well as resourcing developments that helped to instigate reform are explored. A theoretical conceptualisation of community that fits comfortably with these developments is described. The first conceptualisation is of a past "Geographic-Occupational Community" in mental health. With the gradual breakdown of geographic-occupational communities discussed in depth in Chapter Four, the concept of a gradually evolving "Community of Interest" is presented. The

rise of patient empowerment with voluntary organisations, rehabilitation services, and the re-emergence of individuality among the client group is considered in this context.

Chapter Six explores the concept of the nature of "risk" and the way it has evolved as a central discourse in mental health. The chapter identifies the nature of the management of what is now defined as "risk" when geographic-occupational communities in mental health were strong with a work and local community who were nearly coterminous. The earlier management of perceived risk by the concentration of staff within the walls of a hospital is considered. This includes not only the risk of potential violence or the suicide of patients but also risk from disease within a relatively large population concentrated in a walled location. In addition, risks for patients in sometimes-regimented environments are noted. The use of drugs by doctors in situations where staff adjudged the behaviour of patients to be deviant is recorded.

The theoretical concept of the "Community of Risk" discourse is noted as coming into play with care in the community. The management of general deviance type risk through a broad range of assessments, treatment initiatives and education within community services supported by small in-patient facilities is explored. The management of violent risk by protocols, tracking and possibly questionable anti-civil liberties legislation, permitting pre-emptive action is examined. Risk management in the modern mental health services and some of the influences driving change will also be discussed in this chapter.

Chapter Seven revisits and briefly summarises the key outcomes in the research study arising from the results presented in Chapters Four, Five and Six. The outcomes are explored with regard to questions arising from the literature search in Chapters One and Two, and the pilot study. The data gathered in this research is recorded as having been used in an historical account of a time and place, St Crispin Hospital between approximately 1935 and 1965.

Chapter Eight, in conclusion, reveals specific contributions to knowledge and perspectives on concepts of community in mental health.

To begin, Chapter One will briefly explore mental health and social policy in England and Wales between 1850 and 1965.

CHAPTER ONE

MENTAL HEALTH AND SOCIAL POLICY IN ENGLAND AND WALES: 1850 TO 1965

Introduction.

This chapter will explore the social and political background, the legal framework and the provision of facilities created for the identification and containment of those deemed mentally ill from approximately 1850 to 1965. This period covers the major events of the building, in England and Wales, of the asylum system through to the announcement of its end in 1961. Certain aspects of the service and in particular the framework in Scotland has been different and will therefore not be referred to in this study specifically. The manner in which insanity has been conceptualised and the nature of the relationship between the mentally ill and the communities from which inmates were drawn in this period will be discussed. The changing nature of provision will be examined, including the increasing bureaucratisation of the service noted by Arieno (1989:97) during this period. A historical perspective dating from the inception of the system rather than the focussed period of the overall study (1935 to 1965) is appropriate in that it places the radical nature of the changes to a long established system into context.

The chapter will examine the history of mental health and social policy under the following headings:

(1) Background history.

(2) Changes in social policy and the breakdown of previous methods of parish support.

(3) The mentally ill as social scapegoats.

(4) The medicalisation of insanity.

(5) A perceived increase in the number of "pauper lunatics".

(6) The social isolation of the mentally ill.

(7) Institutionalisation, the perception of risk and social control.

(8) A ceaseless demand.

(9) New attitudes to mental illness.

(10) Campaigns for reform: the right to liberty and the Quakers.

(11) Parliamentary reform: the role of legislation in change.

(12) Cost and control: the Poor Law versus the lunacy authorities.

(13) The consolidation of the power of doctors.

(14) The institution as a self-contained community.

(15) The beginning of the end: later developments in the institutions.

(16) Conclusion.

The subjects explored in this chapter will not necessarily follow a strictly chronological order but will concentrate on specific aspects descriptive of the development of the service in relation to social policy.

(1) Background history.

To discuss the changes that occurred in context, it is first necessary to examine elements of background history. The earlier part of the period under consideration, from approximately the 1850s until just after the First World War, represents a time

when large, particularly county asylums (later, "mental hospitals") were developed (Jones and Sidebotham, 1962:7). This occurred when communities were being re-moulded by massive social and economic change caused by the Industrial Revolution. In addition, newly emerging capitalism exacerbated massive differences in living conditions between the wealthy, rural labourers, and what Marx and Engels (1969 [1848]) identified as the emerging proletariat. The extent of these differences was revealed in 1842 when Edwin Chadwick, a Utilitarian disciple of Jeremy Bentham, was commissioned by Parliament to study the administration of the Poor Laws. He presented a "Report on the Sanitary Condition of the Labouring Population and on the Means of its Improvement." One noted detail was about contrasting average life expectancy for the working classes and the gentry (twenty-two against forty-four years). A study by Engels in 1844, "The Condition of the Working Class in England" (that was published in German in 1845), explored the extent of the enormous social changes taking place. This included the expansion and movements of population.

> "The rapid extension of manufacture demanded hands, wages rose, and troops of workmen migrated from the agricultural districts to the towns. Population multiplied enormously, and nearly all the increase took place in the proletariat." (Engels, 1969 [1845]:50)

The social and economic changes caused by the Industrial Revolution affected all sections of society including those on the lowest rungs. One change affected the system of support provided by the "old Poor Law", a change that caused it to begin to break down. Many parishes had combined, after Gilberts Act of 1782 permitted this, into "unions" to deal with poor law needs (Briggs, 1983:196). The construction of workhouses, which enforced labour on able-bodied inmates, increased rapidly

during the eighteenth century. Briggs (1983:196) further comments in respect of the old approach:

> "It was to become increasingly expensive to operate in the early nineteenth century and increasingly irrelevant to the needs of a more industrialized society."

These changes therefore had consequences for so called "pauper lunatics" in their means of support and, it is argued, how they were defined in the first place. This was ultimately reflected in changes in social policy.

(2) Changes in social policy and the breakdown of previous methods of parish support.

The historical social position of the insane can be seen as follows. Early provision was organised by local parishes and presumably, with some family support (Porter, 1987:14). Prior to the coming of complex machinery and the factory system from the eighteenth century onwards, the so-called "Domestic System" based on small and family-based communities was the norm (Trevelyan (1942:37n). The traditional, longer established village community and the "Domestic System" of production, which made possible extended family support of some of the more vulnerable members of society, was failing. Butler (1993:12) describes what he sees as the "decline of the parish as the main way to provide for the mentally ill."

However, this system itself had not been ideal. The condition among the rural poor could be desperate. Butler (1993) describes a problem that had been inherent in parish relief. There was a variation between parishes in the quality of provision. Those living in an area with a more enlightened approach would predictably be

better off than those in a less enlightened area. Foss and Trick (1989:8) comment on the effects of the industrial and concurrent agricultural revolutions and the effect they had on provision for the poor and sick. In respect of the latter, the enclosure of common land had led to the eviction of many small tenant farmers and independent yeomen.

> "The now landless labourers who, until they lost their rights, had been able to cope with their sick, were now forced to search for work in the new, ramshackle towns of the Industrial Revolution where conditions made it increasingly difficult to maintain such family obligations."

Speenhamland in Berkshire utilised systems of "outdoor relief" but this approach was not universal (Trevelyan, 1942:469). It was also seen as ultimately oppressive. In 1795, the Justices of the Peace for Speenhamland implemented the paying of a dole, established by the price of bread, to supplement wages for every "poor and industrious person". This sum was payable from parish rates and had the effect of passing the burden of the payment of a living wage from larger farmers to less wealthy parishioners. It also "compelled the labourer to become a pauper even when he was in full work!" (Trevelyan, 1942:469). A reform of the Poor Law in 1834 stopped relief for the "able-bodied" poor and identified the workhouse as the proper future provision (Arieno, 1989:27). These changes also affected those deemed to be suffering from a mental incapacity.

Provision for pauper lunatics, at the end of the eighteenth and early nineteenth centuries, included a number of charity-supported institutions. One such is The Northamptonshire General Lunatic Asylum, later St Andrew's Hospital. It was first contemplated in 1789 and finally opened in 1838 after being funded by subscription (Foss and Trick, 1989). Similarly, an addition to Leicester Infirmary to care for

lunatics, on a charitable basis, was built by 1782 and The Infirmary Asylum by 1794. These were sustained by subscription (Orme and Brock, 1987:6).

The question of expense for general ratepayers in the maintenance of those deemed mentally "deficient" was of interest at the time. In relation to this, emphasis on a degree of self-sufficiency for new institutions, was always an important issue. For example, the first Medical Superintendent of Northamptonshire County Lunatic Asylum, (later St Crispin Hospital), Dr Milson, was forced to resign after what was seen as unnecessary expense in relation to the higher quality of "cups and saucers" among other things. It was later announced in 1879 that Northamptonshire County Lunatic Asylum was running at a profit, partly because of money received from the housing of out-of-county patients, a development that ultimately caused overcrowding (Scull, 1979:217).

Foucault (1967) dates what he terms as "The Great Confinement" of the insane as occurring during the eighteenth century. Although there may have been such a process in France, it can be argued that it did not truly take wing in the United Kingdom until the early nineteenth century. It was linked in no small part to legislation by central government after it was found, as commented on by Arieno (1989:24) that:

> "...the private sector could not adequately fill the need for supervision and care of the insane."

Foucault (1967) saw the mentally ill as occupying the socially excluded role previously occupied by the leper. It can be argued that a characterisation of those who were confined was as much a part of their inability to economically support

themselves, as any medical diagnosis or social need as outcasts. There can be no doubt however that, of those later termed mentally ill, some ended up as wandering beggars or falling foul of the law and became what we would now call socially excluded.

(3) The mentally ill as social scapegoats.

Examining the characteristic of communities to develop scapegoats, as Foucault does, is not necessarily to diminish the economic advantages to be gained by the provision of care and support to those who would potentially suffer such discrimination. Bodies of individuals, such as those working within the later mental hospitals were formed into self-serving stratified communities, membership of which provided "asylum" as a career. That this may have been an important motivating force is an area that requires further exploration.

Policy initiatives to develop large, economic places of confinement with all the bureaucratic advantages they provided were highly commensurate with the concepts of asylum or refuge. There must also have been a large number of individuals who were recognised as unusual, whether because of eccentric behaviour or learning difficulties, yet who were tolerated by, and who contributed to, their own communities, and thus found a niche within them (Porter, 1987:14). Some such individuals, also deemed "paupers", were given relief within the parish workhouses of the period. One such workhouse was at Kettering in Northamptonshire (Archive Material, St Mary's Hospital, Kettering). Workhouses existed before the great expansion of the asylum system and continued to exist into the twentieth century. Their function for much of that period was also intimately linked to "pauper

lunatics". The way in which this policy gradually changed will be explored in the section that follows.

(4) The "medicalisation" of insanity.

During most of the early time-scale covered by this study, the Union Workhouses catered for a mixed clientele that included a proportion of those deemed to be "lunatics". Provision was deemed as cheaper for an in-mates local parish, than in the private asylums. Earlier in the nineteenth century, this difference would have been at half the cost (Arieno, 1989:27). Arieno, (1989:33) also comments that in 1844, the commissioners in lunacy reported that three quarters of all lunatics were incarcerated in workhouses. Arieno describes the development of asylums as part of the evolution of a social service delivery system "spurred by the social consciousness of the era". The issue of whether "lunacy" was fully a medical responsibility was not, in practice, decided at this time. Where help should be provided and what form it should take led to at least one unusual situation. Jones (1993) mentions that the St Peter's Workhouse in Bristol (which was founded in 1693) unusually cared for the mentally ill as such and identified them as requiring treatment "as distinct from confinement".

Jones further notes that another policy adopted by the Bristol authorities, which was to influence later reform, was the accepting of those deemed insane as a public responsibility. The conflict between the workhouses and the new asylums later in the nineteenth century, over this group of people, will be examined later in this chapter.

(5) A perceived increase in the number of "pauper lunatics".

During the nineteenth century, in such a time of radical change, the situation of those at the bottom of the social ladder was, as already noted, often desperate. An increase in the population of the poor law institutions was also marked by what was seen as an increase in the number of the "officially recognised as insane" during the nineteenth century who were consequently admitted (Arieno, 1989:115). Whether this was as a result of an increase in mental illness, changes in categorisation and the development of services, or a breakdown in the support structures provided by older communities will be considered next.

The concurrent population explosion, it is reasonable to assume, must have affected the numbers requiring relief. Furthermore, the effect on individuals who could not adapt for any number of reasons including because of unemployment, enforced occupation changes or because of age must also have been important. However, Arieno (1989:33) comments on the increase in population of the insane at this time, which was influenced by a concurrent flow of patients from the workhouses into the asylums. Arieno (1989:33) maintains that the individuals concerned were not in fact reflective of a fresh institutionalisation of social misfits, "thereby negating the basic assumption of the social control theorists." Arieno in particular attempts to refute Skull, (1979:250) who comments, "I have suggested that asylums were largely dumps for the awkward and inconvenient of all descriptions". However, it cannot be disputed that such a flow did take place from parish control to the new institutions.

The 1828 Lunacy Act required the provision of asylums within each county for pauper lunatics as part of the process of the introduction of "certification". When

counties refused to build the institutions, those deemed insane were often admitted to workhouses (Midwinter, 1994:63). However, a further act in 1845 made it mandatory for the building to be carried out (Arieno 1989:15). However, even as late as 1892, there were still "pauper lunatics" on the books of the Kettering Workhouse (Archive Material, Rockingham Forest NHS Trust).

Note: The legal term of "pauper" was abolished by the Local Government Act of 1929 and one of the provisions of the Mental Treatment Act of 1930 was to replace the term "lunatic", "except in certain specific legal contexts, such as 'criminal lunatic'" (Jones, 1972:352) with other phrases including "patient" or "person of unsound mind". The term "pauper lunatic" was therefore replaced by "a rate aided person of unsound mind" as a result of these Acts. (Jones, 1972:352)

From the opening of the county asylums, and throughout the nineteenth century, the demand for beds never kept up with the supply, and conditions became overcrowded very quickly. During this time workhouses continued to function and receive a flow of admissions, as noted above. This would indicate that the apparent increase in insanity was influenced by other factors as well as the transfer of patients from one institution to another. Arieno (1989:32) sees the increase as also being due to increased bureaucratisation in mechanisms of social services delivery as a factor in changing, and reforming, social values. This may certainly have been one reason, but it could be argued that there was more involved in the policy than altruism. If a part of the population that was "unwanted" had grown, what was the origin of this growth and what were the forces that drove increased bureaucratisation and the urge for reform? However, in respect of the supposedly poor and disaffected background of those admitted, Arieno (1989:82), in presenting a study of patients in the Bethlehem

Hospital in 1848 that considers such things as literacy, education and trade, concludes that "the evidence presented shows that the inmate asylum population in this study corresponded positively to the general population of mid-century England."

(6) The social isolation of the mentally ill?

There was social stigma towards the poor within the relatively small communities responsible for their support. As noted by King (1991:15), fear of "abuse" of cash handouts, thus "maintaining a feckless way of life" was sometimes present. After Victorian policy makers "agonised" over an approach to this problem the "result was a policy based on 'indoor' rather than 'outdoor' relief". As noted in relation to workhouses, institutional life carried stigmas of its own. The additional isolation from outside communities exacerbated the effects of this. For example, Ramon (1992:xiii) cites sociologists as concluding mental hospitals to be;

> "...social institutions that maintain people judged to suffer from mental illness by segregating them as deviants from the rest of society."

Some could see merit in social isolation as noted by Tomlinson, Carrier and Oerton 1996:117):

> "As with sociologists, some of the later clinicians could be seen to find merit in environmental poverty and the separation of the mentally ill from society which was offered by mental hospitals."

Gittins (1998), in her exploration of the work and culture of Severalls Hospital from 1913 to 1997, describes a world estranged from that outside before the beginning of change in the 1950s and 1960s. Butler (1993:41) talks of the heart "of the search for alternative approaches to the use of the large old hospital isolated from local communities". Whether the degree of social isolation experienced certainly by many

later asylum inmates was as total as inferred is open to question. The issue will be explored more fully in the results chapters, in which original data is presented.

By contrast, when they appeared the new asylums were seen as what Porter (1987) describes as a "utopian" answer that provided luxurious, even grand, accommodation for the afflicted. However, these hospitals were constructed at a time when a genuine nostalgia for what were seen as more humane social structures existed. This is noted by Briggs (1983:214) in his comment on Engels' mention of earlier writers

> "...like Peter Gaskell, who regretted the decay of 'community' and the values that went with it, claiming that 'the domestic manufacturer, as a moral and social being, was infinitely superior to the manufacturer of a later date.'"

Engels (1969 [1845]:98) comments that Gaskell was a Liberal;

> "...but wrote at a time when it was not a feature of Liberalism to chant the happiness of the workers. He is therefore unprejudiced, and can afford to have eyes for the evils of the present state of things, and especially for the factory system. On the other hand, he wrote before the Factories Enquiry Commission, and adopts from untrustworthy sources many assertions afterwards refuted by the report of the commission."

Although the rapid growth of the factory system and the movement of population from the countryside to the towns undoubtedly created appalling conditions in some areas, it could also be argued that a similar concentration of the mentally sick into large, geographically isolated, and specialised institutions was similar in many ways to the path that industry was taking. It could be argued to have been a reflection of trends towards economy of scale that also created occupational communities among, for example, workers in boot and shoe manufacturing industries, in Northampton, at the end of the nineteenth century. Allied to this, where mental health was concerned, there remained an image of the ideal largely rural past.

Webster (1993:196), in referring to this massive programme of building, sees advantages for the medical profession being an important factor. He comments:

> "It is difficult to excuse the huge programme of building of workhouses, asylums, mental deficiency institutions, sanatoria, or infectious disease hospitals in the nineteenth and early twentieth century on grounds of real need. More appropriate, humane and cheaper would have been relief within the community or more prompt use of vaccination and immunisation. Yet incarceration and building of vast hospital networks was favoured by the elite and it advanced the status of the medical profession."

The power of the medical profession was to be further enhanced with the founding of the National Health Service in 1948. This will be examined in more depth later in this chapter in considering the consolidation of the power of the medical profession.

It can be argued that nostalgia for aspects of a largely rural past influenced the grandiose "country estate" design and structure of the new asylums, which, as their name implies, were literally portrayed as refuges from the harshness of the then modern world. However, they largely failed to re-create a rural idyll.

Allied to radical social change, came the conflict created by such changes. The social and political background influential in the development of theories of social control with regard to those deemed insane in this period will be examined next.

(7) Institutionalisation, the perception of risk and social control.

In 1789, there was revolution in France. Rude (1966:300-301) comments that it would be a distortion to consider the whole subsequent history of Europe as a projection of the revolution. This was particularly true in England and Russia where it had little direct influence. In Britain, however, there was social unrest, following in

particular, the end of the Napoleonic Wars when many of the poor were affected by economic depression. Disturbances began in some areas with the introduction of the Corn Bill in 1815 with a corresponding high price for bread (Morton, 1938:354). Political agitation took place against a background of major events such as the Peterloo Massacre in Manchester in 1819 (Briggs 1983:226). Early trade unionism and the rise of Chartism reflected major change to the industrial infrastructure. In 1812, the Prime Minister, Spencer Perceval was assassinated by a dissatisfied businessman, (Porter, 1987:179) described as "a maniac named Bellingham" by White (1986 [1914]:148). Bellingham was however executed before any meaningful assessment of his mental state could take place (Porter, 1987).

The rate of change with the accelerating industrial revolution led to massive social change. In England, Rude (1964:301) comments that the industrial revolution, in the long term became

> "as potent a force for social change as the political revolution originating in France. It was from the former rather than the latter revolution that there emerged an industrial working class and the new dominant social conflict between capital and labour; and modern socialism, as formulated by Marx, derived as much from England's industrial experience as from the teachings of the *philosophes* and the French revolutionaries."

It is not being suggested that institutionalisation of the mentally ill was consciously related to efforts to prevent revolution or control class conflict in emerging industrial society. However, the issue of efficient social control was a thread running through the period in question. For example, in terms of the criminal justice system, changes were also taking place. Cowley (1998:3) notes that in respect of policing "...by the early 1800s, society had changed so much that the "old" system just could not cope anymore." Reform led to the "new" system that occurred first in London in 1829 and

was adopted gradually as the new "provincial" policing, with county constabularies throughout England. Steedman (1984:4) comments on a "belief in the power of an institution to alter and improve social and class relations that has dictated much of the police history that has been written in the past fifty years."

Mental illness has, and has been given, a capacity to induce fear (Foucault, 1967:211; Gittins, 1998:51). Butler (1993:15) describes the stereotype of the mentally ill as being pitiful or dangerous. Current mental health legislation accepts a reason for compulsory detention as being based around the notion of an individual who provides risk, being a danger to him/herself or others. The fear of assassins and ideas that conflict with the maintenance of the status quo can lead to the invoking of mental health regulations. Porter (1987:21) comments on fears of the "degenerate" masses who could wreck civilisation with their "mental imbecility or savagery". Interestingly, Scull (1979:55) reports the acquittal, on the grounds of insanity, of a would-be assassin of George III.

Although not constructed as a formal concept of "risk" governed by strict protocols of "risk assessment" as in modern services, a fear of the hypothetical unpredictability of the "dangerous individual" has been a thread running through the history of mental health provision. In the days of the large institutions, these factors were dealt with by concentrating the mentally ill in one walled geographic area. They were governed by militaristic routine and supervised by rigid policies, procedures and protocols. Within the walls there were other levels of confinement for those considered potentially dangerous or at risk of self harm. Again, these would be based on areas within the geographic area of the hospital, the refractory wards, or for the

physically sick and potentially infectious, isolation areas. Each area would again have its own even more restrictive levels of supervision. This could best be described as circles of restriction within circles of restriction.

We can see precursors of the present day interest in risk in the way that the perceived hazards of insanity were managed politically, institutionally and medically in the late nineteenth century. The issue of the concept of risk will be discussed in more depth in Chapter Six, The "Community of Risk" where it will be considered in respect of modern societies. Emphasis will be placed on the work of authors such as Beck and Giddens who have written in depth on the concept of risk during the late twentieth and early twenty-first centuries.

(8) A ceaseless demand.

In the nineteenth and the first part of the twentieth, century, as already noted, no matter how many asylums were built they were soon overflowing. Scull (1979:30) considers the protests of those who argue that the rise of capitalism in England had begun too early to influence events that happened in the late eighteenth and early nineteenth centuries. It is argued by Scull (1979:30) that there is no clear relationship between the building of large asylums and city growth. Scull asserts that the whole of society was reorganised "along market principles". It will therefore be instructive to explore both the extent to which asylums had something of the traditional sense of rural community about them, as well as the extent to which they had much of a sense of industrial community as well. Original data on this subject will be presented in chapters four and five.

The care of those deemed insane was rationalised within regimes that combined Utilitarian principles of good governance, "in the interests of the greatest number", as much as they incorporated any pretence of moral and liberal approaches to care. Principles of efficiency were used to make possible provision for the constant flow of inmates. Further economy of scale led to early enlargement of many hospitals (Scull, 1979:117; Wainwright, 1992:6). Ultimately, with overcrowding, the ability to provide the sort of individual attention that may have made life better, faded.

In the period before the rise of industrialisation, an agricultural economy conditioned a society governed by the importance of natural phenomena, or the divine, both factors outside of the control of humanity. Lunacy could be seen as God-given, or a result of fate, and although the afflicted could be contained, their condition could not be changed subjectively.

Capitalism provided a force by which people changed the landscape and, in the view of Marx, by which people sought to control and conquer nature. The new workforce, leaving the land and moving to factory work had, in the words of Scull, (1979:71) "to internalize the new attitudes and responses, to discipline themselves." This discipline was necessary in order to participate in the new industrial system. An implication of this outlook was the emerging view that the insane also had a capacity to change if the right measures were used. The so-called "moral" approach to care and treatment stemmed from this basic proposition. This was based on a foundation of "fair but firm" discipline, society and occupation within a conducive and relatively small social group. This approach was "at the cutting edge" of care from

the latter part of the eighteenth century (Houston, 1999:38) and will be discussed in more depth later in this chapter.

(9) New attitudes to mental illness.

The concept of "mental illness" as such was reinforced by the "madness" of King George the Third. The "Lords anointed" could not be mad because of "sin". He was treated by means of an occasionally strict and coercive approach. It has also been postulated that the fact the King should be so afflicted, helped change some contemporary attitudes to insanity in excluding such "moral condemnation" (Scull, 1979:129).

The search for effective treatments in general, originated in a medical philosophy that won control of the asylums and then needed to justify this control through the search for a cure. This would be by scientific, initially reductionist, methods. Medical control brought with it particular problems of its own, as already noted, with sometimes barbaric treatments. However, a view of mental illness as physically based did, as noted by Arieno (1989:69), also carry the implication that the new biological scientific approach might ultimately find a cure. No longer was the aim to shock, by sometimes-brutal means, the patient back from "unreason" to "reason" as referred to by Foucault (1967). Jones (1993:39) sees the doctors as better than nothing in that at least they were educated, could identify physical disorders and "guard against the spread of infectious and contagious diseases in the asylum." This may have been the case, but the presence of doctors as guardians nonetheless set the basis for the medicalisation of institutionalised care. This meant that not only obviously psychotic conditions such as what is now termed schizophrenia would be

categorised under the heading of "illness", but that any failure of social adaptation could be (and is), interpreted within a medical paradigm. The philosophies underpinning approaches to the mentally ill had therefore moved from mental abnormality as an act of God, through to a result of physical or moral failure, and finally to the individual being viewed as a passive and powerless victim of sickness. How successful the medical model has been in mental health is worthy of further exploration.

(10) Campaigns for reform: the right to liberty and the Quakers.

Precedents set in France during the Commune of 1789, when the influence of the concept of liberty and the rights of man were prominent, saw the chains of "lunatics" struck off by enlightened reformers. One of the best remembered of these reformers is Dr Philippe Pinel, who was physician from 1793 to 1795 at the Bicetre Hospital in Paris. He initiated humane and progressive changes while supporting earlier and continuing reforms developed by the Head Attendant Jean-Baptiste Pussin and his wife. Pinel was also supported in his work by Pussin (Nolan, 1993:28). In Italy, "emancipatory visions of Chiurugi" are noted by Porter (1987:19), as are psychiatrists influenced by the Romantics in Germany.

In England, incidents at the York Asylum affecting a Quaker patient led to the Quakers establishing an institution of their own in 1792. This institution, "The Retreat", came under the guidance of Samuel Tuke, and was a significant model in the field concerning future planning in mental health. A "Description of The Retreat" was published by him in 1813 and proved to be influential. The institution workforce was involved in developing the principle of "moral treatment" mentioned earlier.

The Quakers had explored the medical expertise available at the time but rejected it. This initiative came when there was general disquiet about the quality of provision for the insane and when social reform had much prominence. More or less contemporary campaigns included those by individuals such as Wilberforce and Fry who were fighting for the abolition of slavery and prison reform respectively.

The philosophy behind the work at "The Retreat" was based on a relatively small, intimate establishment that enabled the development of supportive family type relationships within it. In this respect, scale was a critical factor allied to the particularly benign and tolerant social convictions of the Quakers. To attempt to use such principles as a model for vast structures, housing from one to two thousand patients, was clearly ridiculous. "The Retreat", therefore, for all the possibilities that it showed, and for all the undoubted successes it achieved, was, it is argued, not in the end as influential in a practical sense as is often claimed. Rather it can be suggested that "The Retreat" represented an unfulfilled promise of what might have been had social tolerance become, and had scale not become, part of the equation in the generation of mental hospitals.

Moral treatment, the invention of "laymen" (Scull, 1979:132), and heavily influenced by the work at "The Retreat", initially represented a threat to medical autonomy and the concept of the traditional treatment of insanity as a doctor defined "illness". However, the ineffectiveness, and even harm, caused by medical treatments led to doctors seeking a way of "accommodating" the approach as they sought to re-establish their waning influence (Scull, 1979).

With such an interventionist approach, was there an underlying intention to return inmates to the labour market where they may again compete, as has been postulated by Scull (1979:72)? If this is so, why was the policy so markedly unsuccessful? There was never full enough employment in the capitalist economy that was developing to make this outcome critical. It is, according to Marx (1930 [1867]:214), inherent in a capitalist economy is that there is always a pool of unemployed ("surplus labour") available and with the relatively low numbers in the mental health system at any one time this was never going to be important except to the patients themselves. It would, however, not be good for social stability or acceptable to the more humane to see individuals perhaps starving on the streets. This was approached monumentally, with the building of the asylums. The very nature of the communities that developed made it difficult for those within them to leave.

Of more significance is the body of labour involved in the communities operating the hospitals themselves. An industry of care for the insane "with a professionalised group of managers of the mad" (Scull, 1979:43), developed from the end of the eighteenth century and existed alongside the medical initiative. It can be argued that the asylums, along with the Poor Law institutions initially, in fact commodified interventions in supporting a group of the population that could not adapt to the new market economy. They commodified containment and the provision of subsistence to a group that would in the main be unlikely to rejoin the outside labour market. However, much previous research fails to acknowledge that many of those who had been institutionalised contributed both to the hospital and to the local economy. Much of this work was defined as therapy, and indeed may also have had therapeutic effects. However, this definition may have drawn attention away from activities that

had other, real, economic effects and the activity must therefore be viewed in more than one way. These issues will be explored further in the results chapters four and five.

(11) Parliamentary reform: the role of legislation in change.

It is impossible to consider the issue of mental health without linking it to an assessment of legal issues. There is, and has been for a long time, an intimate relationship between the two that has been formative to the development of the structures and policies being explored. An early issue of contention in the mental illness "business" was expressed in conflicts of influence between the "mad doctors" and lawyers over the principles of the power of detention of those medically diagnosed as insane. The holding of some individuals, often wives, whose incarceration would give financial advantages to spouses or other family members led to concerns about the accuracy and impartiality of the medical men. For the wealthy, there were private "madhouses", if the person considered to be afflicted was not locked up in their own home. Concern about the treatment of this group led to moves for reform that later affected the whole population of detained patients. These issues led to a number of high profile legal cases. Porter (1987:118) describes the case of Louisa Lowe and her protest against wrongful confinement by her clergyman husband because she had adopted spiritualism.

Allied to this was publicity about atrocious conditions in some of the existing institutions (Butler, 1993:7). These issues galvanised a motivation for reform. Prominent among those campaigning for change and who had considerable parliamentary influence was Lord Shaftesbury, the 7th Earl, who was chairman of the

English Lunacy Commissioners and "chief spokesperson for the Lunacy Reform Movement" (Nolan, 1993:34). Nolan (1993) also records Shaftesbury's influence in the passing of the 1845 Lunacy Act and his support for the development of an asylum system that would replace the mixture of facilities housing those deemed mentally ill at that time.

An earlier legal requirement of certification for private patients considered to have lost their reason was passed by an Act of Parliament in 1774. Scull (1979:151) interprets this as a move by the medical profession, who carried out the diagnostic preliminaries to certification, to further develop their attempt to obtain a monopoly of the right to define mental illness. The attempt was successful and doctors have played the key role, retaining a monopoly of the legal right, under mental health legislation, to define and diagnose mental illness from then right through until the present. Although others may make their own diagnoses, as in the case of psychologists for example, only doctors can apply for admission for detention under the terms of the 1983 Mental Health Act as they could under the previous 1959 Mental Health Act. The nature of legislation passed by the parliamentary reformers will be considered further, later in this chapter.

Although the authority of a doctor had been believed a protection against the wrongful detention of the sane, as has already been noted, abuses still occurred. Following a Parliamentary Select Committee Report in 1827, The Madhouse Act was passed in 1828. To the considerable chagrin of the medical profession, the 1828 Bill introduced a system of inspection in asylums by commissioners that included a lay presence. Although this sounds a very significant development, it only covered

private madhouses in the London area. Of the Metropolitan Lunacy Commission, only five were medical men (who received payment) and fifteen were laymen (who did not). Of the laymen, it is noted by Jones (1993:109) that eleven were members or ex-members of parliament and that the majority were evangelicals. A campaign by the legal profession for representation led to a further Act of 1832 that required two lawyers to be included on the commission. However, in a setback for the lay members and against a background of complaint by physicians that areas of clinical judgement were being questioned, a stipulation that lay members should accompany doctors on visits was removed.

In these disputes, the ultimate victory is given by Jones (1993:153) to the lawyers. Lawyers were members of an older and more experienced profession than the doctors who were just finding their feet. The outcome established strong legal protocols and safeguards in the detention of those deemed insane that continue to exist. A similar contemporary standoff has developed over the withholding of the artificial provision of food and water on medical authority alone (but with some consultation), from those who in the doctor's judgement have terminal conditions or have no chance of recovering a meaningful conscious existence. This modern issue, originally thrown into public prominence by a British Medical Association discussion document for the establishing of guidelines, comes however, at a time when physicians and surgeons are much more powerful and influential in relation to lawyers than they were at the beginning of the nineteenth century.

In 1842, a Bill was initiated that again changed the number of Lunacy Commissioners to between fifteen and twenty. Of those, four were to be legal

commissioners and six or seven medical. The real change introduced by this bill was that it expanded the area of scrutiny to include all institutions apart from the Royal Bethlem and required a detailed inspection by the medical and legal members combined. The report in 1844 dealt with many issues that had first been examined by the Commissioners in 1828 (Jones 1993:81). These included "classification, ventilation, heating, diet, cleanliness, exercise, occupation, education" and leisure activities. This report was significant in that it sought to establish a blueprint for what became the great confinement in Britain, the eventual building of the asylum system around a centralised, uniform approach.

A recommendation was made for the extension of the lunacy laws to apply to every type of institution, including the better keeping of records, improved certification procedures, and protocols for inspection by the authorities. It also advocated the building of county asylums, and even advised that a central planning body should help with the choosing of sites for the institutions, approve plans and scrutinise estimates. The monumental expansion of the bureaucratic structure was thus planned. The subsequent 1845 Lunatics Act named a new National Lunacy Commission that consisted of three lawyers, three laymen and just five medical men, and guidelines were laid down in detail for their duties, powers and responsibilities. This act, it can be argued, laid the basis for the asylum system for the next one hundred and thirty years. Although details, treatments and attitudes changed, the main fundamentals of the system remained intact and the foundations were laid for the local communities that were to develop around the asylums. Always included in this shifting field, was the sometimes uneasy, fluid relationship between the claims of medical expertise and human rights, as has been discussed.

Further legislation came with The Lunacy Act of 1890. The result reflected a determination through law to control processes concerning liberty.

> "From a medical point of view, the Lunacy Act of 1890 was out of date before it was passed. It represented the legal view of mental illness – that here was a condition which made it necessary in certain circumstances to deprive a man of his personal liberty, and that every possible device must be used to limit these circumstances." (Jones, 1993:226)

The legislation is described also as drawing a legal boundary between the majority who were sane and the minority who were not. This followed further concern about wrongful detention by doctors.

Preceding this Act, Parliamentary Select Committees, first in 1859, and then especially the second in 1877, explored issues of wrongful confinement. The suspicion is that there remained a particular fear among wealthier people that they would be wrongly detained because of continuing abuses in the private asylums. Regardless of the inspections by Lunacy Commissioners, it can be inferred, simply by the numbers involved, that there would be little redress for those from more humble backgrounds.

"Certification" was a basic requirement for committal to the public asylums. This increased stigma by making admission a last resort. Ultimately, to allay the fears of the better off, A Lunacy Acts Amendment Bill was introduced requiring magistrates to issue orders for admissions to private hospitals. This legislation included, as Jones (1993:174) notes, provision to protect doctors from "vexatious actions" against wrongful detention. It was also seen as a protection for potential patients.

By the time of the 1890 Lunacy Act, a second wave of county asylums was in the process of being built (or already had been). These included the Northamptonshire County Lunatic Asylum that was opened in 1876. The accommodation provided was for 540 patients:

> "...at a cost of £162,176 14s. 7d. including cost of land, erection and furnishing, and governed by a Committee of Visitors appointed by the Court of Quarter Sessions. An additional 230 beds were added by 1888 making a total of 770.
> On the passing of the Lunacy Act, 1890, the Hospital was governed by a Committee of Visitors appointed by the Northamptonshire County Council. Between 1890 and 1914 an additional 50 beds were added together with a small Isolation Hospital and a new Laundry." (Archive Material, Northamptonshire Record Office – See Appendix Four)

A rigid gender divide was continued in the new institutions as in the old. Gittins (1998:127) describes the division between men and women as resulting in them living "very separate lives". The degree of separation is worthy of further exploration and will be discussed in Chapter Four.

The first wave of new institutions had followed the Lunatics Act of 1845 (Jones and Sidebotham, 1962:7). The Local Government Act of 1888 had established County Borough Councils, and the asylums ceased to be under the control of Magistrates in Quarter Sessions. They were placed under these new authorities by the 1890 act. The Mental Treatment Act of 1930 did not repeal the 1890 act but complemented it. "Voluntary patients" and "temporary patients", who were considered to be suffering largely from what were described as neurotic conditions rather than psychotic ones, were able to be admitted for the first time. It was believed that this development would open the service to those who had previously been deprived of inpatient care

in that their conditions did not warrant certification. In practice, the powers of the doctors to place voluntary patients on a detention order or to extend an initial assessment order placed on a temporary patient were extensive.

Additional buildings were sometimes built and utilised for voluntary patients, such as "The Pendereds" at St Crispin Hospital in Northampton, after the 1930 Act (Archive Material, Northamptonshire Record Office). This unit consisted of two separate but interconnecting wings, one for men and one for women. It was designed to reflect the latest medical technology and incorporated a laboratory and an X-ray Unit. The building, although within the grounds of the main institution, had its own separate entrance from the road and was built in a different style.

In the case of St Crispin Hospital, considerable local folklore developed around the new Pendered Unit in the grounds. The extent to which these additional buildings became separated, in the psyches of some in local communities, from the stigmas of the old asylum buildings will be explored in the results Chapter Four.

There is evidence, derived from both oral accounts and archival material, that during the years of the Second World War, there were considerable problems, financial, material and of staff shortages within St Crispin Hospital. The financial difficulties in particular were to some extent solved in the immediate post-war years. This came about primarily as a result of the founding of the National Health Service in 1948 following the Beveridge Report, formulated during the war years in 1943 (Duffin, 2000:129). The founding of the National Health Service in 1948 was influential in that it began a period during which new policies for health and social care were

developed. Allied to this was better financial resourcing of the service. After there had been a shortage of funds, there was suddenly money available. The effect of this extra funding will be explored further in results Chapter Five.

The Mental Health Act of 1959 introduced a number of new and significant aspects consolidating trends that had been developing since the 1930 Act. The term "mental disorder" was defined and provision was made for the admission of "Informal Patients". In practice however, these patients could not discharge themselves without first seeing a doctor and might then have found themselves formally detained. This remains true today and powers to detain for short periods, in emergencies in hospitals and before the arrival of a doctor have since been expanded, under Section 5 (3) of a new Act in 1983, to include nurses. The nature of the kinds of formal admission and safeguards and rights of appeal were outlined under the 1959 Act. Mental Health Review Tribunals were also instituted as part of this Act.

Unfortunately, the provision of external residential accommodation recommended by the Act rarely happened unless the local authority was particularly co-operative. The community workers, previously called "Duly Authorised Officers" were re-named Mental Welfare Officers in 1959 (Butler, 1993:27).

Practically, the 1959 Mental Health Act laid down the framework of what could have developed into a more "community" based service if, in particular, health and local authority services had worked better together. The legacy of the institutions made this an onerous task. However, while the act was still in force more services outside of hospitals, and rehabilitation programmes led by enthusiastic individuals,

began to appear. There had been outpatient clinics, as in Northamptonshire, since the 1930 Mental Treatment Act. The first Community Psychiatric Nurses had begun to work out of Warlingham Park Hospital just a few years before the 1959 Mental Health Act (Leiba, 2001:8). The issue of cost has never been far below the surface in mental health, however, and problems of demarcation and responsibility between health and local authority services are not new, as will be considered next.

(12) Cost and control: the Poor Law versus the lunacy authorities.

As already noted, the issue of cost has always played a prominent role regarding services for the mentally ill and in 1838, this was used as a reason for a Select Committee, working on the Poor Law Amendment Act, to argue that the supervision of "Pauper Lunatics" should be transferred to the Poor Law Commissioners (Jones, 1972:127). It is possible however to see in this a rearguard action by the bureaucracies of the Union Workhouses to regain charge of human commodities of which they were about to be stripped. Cost was, and is, a powerful weapon to use and was especially so to local ratepayers then. The major line of demarcation between asylum and workhouse was drawn at the point of "custody or treatment" with the workhouses wishing to pass on those who were providing a risk of violent behaviour. A prohibition of detaining dangerous, mentally unsound individuals in a workhouse was instituted by the Poor Law Commissioners in 1842 (Jones 1972:130). The asylums wished for those who were "treatable or curable". In 1842, the Poor Law Commissioners directed that medical treatment was favoured, and therefore admission into asylums. A "grant-in-aid" of Pauper Lunatics of 4 shillings per head for every one removed to the asylums was authorised by the government in 1874. This reduced the local rates. However, the "issue was to be fought over locally

for many years" (Jones 1993:75). The price asylum inmates paid for this recognition of their need for "treatment" as a separate class rather than (potentially) just temporary support however, could be said to be a higher one than those who remained behind in the workhouses. Once in an asylum, it was not easy to get out. The bureaucrats can be conceived of as being jealous in their control of those whose misfortunes justified their employment.

(13) The consolidation of the power of doctors.

Before the 1858 Medical Act legitimised their role, the medical staff of the asylums had, in 1841, formed the Association of Medical Officers of Asylums for the Insane, a body designed to lobby for their interests. In 1865, this became the Medico-Psychological Association. This body set standard examinations for attendants, or nurses, right up into the middle of the twentieth century. This fact undoubtedly contributed to mental nursing being pressed for a controlling influence over its affairs, by the medical profession, for a considerable time. This was of course also the case in the nursing field in general hospitals. It helped to initially suppress and then impede the emergence of potential alternatives to the medical treatment model in the asylums and maintained an almost feudal status quo. This is significant because the asylum doctors wanted to be seen as being just as high in status as their colleagues in other fields in the period after 1858 but were aware:

> "that their work was only marginally 'medical', and that there were non medical groups who made claims to expertise - in particular senior asylum nurses who often knew the patients better than the doctors did, and the lay commissioners in London." (Jones, 1993:93)

Despite this controlling influence, many progressive initiatives were still developed by nurses and other non-medical staff. Some of the initiatives, revealed in original data, will be explored in chapters four and five.

As already noted, the principles of "moral management" and non-restraint that were non-medical, were the only real skills available prior to the introduction of new drug and psychotherapeutic approaches that were largely of a distinctly medical origin. Regardless of this fact, the doctors were far better organised as a profession. Ultimately they succeeded in establishing, and indeed Szasz (1972) would argue creating, mental illness as a concept to be managed and treated by them in an established medical way. This was in hospitals with consultants having control of "beds", as did their colleagues within general hospitals. Legislation thus finally underlined the victory of doctors and rewarded their lobbying and critical journalism.

A Royal Commission between 1924 and 1926 concluded that there was a relationship between the mind and the body and that mental illness should be acknowledged as such and dealt with as a public health issue. As noted by Jones, (1993:132) this boosted the medical speciality to a new, higher level of prestige. The Commission also recommended, however, that a stress should be placed on the treatment of patients within their own homes and that prevention should be emphasised. Both of these points can be seen as uncomfortable for the doctors who had just presided over approximately one hundred years of incarceration. However, there was little immediate significant change, if any, for the thousands of inpatients. Medical terminology was adopted by the commission. In the resulting 1930 Mental

Treatment Act, the term "lunatic" was replaced by "person of unsound mind" (apart from the legal term "criminal lunatic"). There was an inducement to develop outpatient clinics and observation wards. In a significant finalisation of the triumph of medicine, the word "asylum" was replaced by "mental hospital".

Doctors very nearly missed out, however, on their final empowerment, with the establishment of the National Health Service in 1948. As noted by Willcocks (1967:100):

> "In 1939 the bulk of provision for the care of the mentally ill and mentally handicapped rested with local government. Central responsibilities were divided between The Ministry of Health and the Board of Control. The legislation which governed these services and responsibilities was long and involved, so much so that the task of reviewing the legislation and services seemed to Ernest Brown to be a formidable one. He decided therefore, not to include the mental health service in his plan for a National Health Service, a decision which the British Medical Association roundly condemned. Willink was braver and in his White Paper he restated the difficulties of reforming the laws governing the mental health services, but declared that the government was determined to include them: 'The aim must not be to reduce the distinction drawn between mental ill-health and physical ill-health and to accept the principle declared by the Royal Commission on Mental Disorder that the treatment of mental disorder should approximate as nearly to the treatment of physical ailments as is consistent with the special safeguards which are indispensable when the liberty of the subject is infringed' (White Paper, 1944)."

This was an important decision, not only for the general direction the service was to take but also to reinforce the domination of the medical profession. It gave them, at last, a formal level of prestige in seeing themselves as on a par with their colleagues in general hospitals. In addition, however, the loss of local funding and direct management as well as increasing medicalisation also had the effect of making the hospitals more isolated. This subject will be revisited later in the chapter and in the results Chapter Five. This will, in particular, be in respect of new physical treatments

that were also influential with regard to increased power for a medical model approach to care.

In the mental hospitals, the nature of life differed extensively from what would be experienced in a general hospital. Beneficiaries of the system ranged from members of the Lunacy Commission through doctors to attendants, gardeners, farmers, artisans and all others employed in the asylums. A powerful branch of the medical profession developed the work and ensured the pre-eminent place for itself in the hierarchy with the increasing bureaucratisation of the service. Foucault (1967), in considering the medicalisation of insanity, and the requirement of confinement resulting from this, states that we are mistaken in believing that it was related to curing the sick. In his opinion:

> "What made it necessary was an imperative of labour. Our philanthropy prefers to recognise the signs of a benevolence toward sickness where there is only a condemnation of idleness."

The nature of the industry associated with the care of the inmates of mental hospitals at this time deserves a closer and more detailed look and will be explored in this research project. As already noted, asylums were expected to pay their way.

Farms, upholstery shops, carpenters and other trades on the hospital sites, often using patient labour, contributed to making the asylums as economically self-sufficient as possible and therefore cheaper for the local ratepayers. Patients imported from other counties based on contracting could save further money, as could expansion of the number of private patients. Northamptonshire County Asylum also had its own water well (Archive Material, Northamptonshire Record Office). Doctors established

themselves as the virtually unquestioned "squires" at the head of these hierarchical establishments. Medical Superintendents might have a house in the grounds and a coach and horses although some had rooms within the main institution, as did Dr Wing at Northampton General Lunatic Asylum in 1860 (Foss and Trick 1989:93).

Around these institutions, a veritable industry developed, which may also have formatively influenced the local communities. Besides the effects of institutional life on those who existed in these communities, the mental hospitals provided employment for thousands nationally. This industry had developed around issues of categorisation, control, supervision and support. The influence of mental hospitals within local areas of occupation must have been considerable but is under-explored in extant literature.

Lifetimes were spent in hospitals by those who were committed - sixty years was not uncommon. Goffman (1968) wrote perceptively of his experiences during the middle of the twentieth century in analysing institutional life in four essays brought together in the work "Asylums". Although he was writing about American institutions, anyone with experience of the larger hospitals in Britain, such as the author, can recognise aspects of his findings. Goffman, (1968) stated, that what he termed "total" institutions, have characteristics that are uniquely theirs and that these qualities apply to other institutions as well as mental hospitals. Central causative factors of the condition termed "institutionalisation" in patients (and staff it has been argued) outlined in Goffman's analysis were as follows. First, all living activities are in one place under one authority; second, daily activities are in the company of many

others who are expected to do the same things together; and third all activities are "tightly scheduled", imposed under rules governed by officials.

> "Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution." (Goffman, 1968)

Of the many thousands of inmates, some had been admitted for reasons that would now provoke outrage (such as "moral deficiency" in young women who became pregnant out of wedlock). It was however, because of the effects of years of institutional life, found to be very difficult to develop sufficient volition in many to help them to leave. Rehabilitation of such people, as noted earlier, from the effects of long-term institutionalisation became a skilled speciality.

Therapeutic optimism had begun with new treatments in the 1930s. At St Crispin Hospital, a Pathology Laboratory and an X-ray Unit had been incorporated into the new Pendered buildings by the middle of the 1930s (Research Notebooks: 9/5/2005). Optimism continued into the post-war period with the discovery of new drugs, and particularly members of a group derived from the phenothiazine molecule, for example, Chlorpromazine Hydrochloride (Largactil) and Prochlorperazine Maleate (Stematil). The phenothiazine molecule, that had been investigated by French research workers and first used clinically in 1952 by two European psychiatrists, Delay and Deniker (Trick and Obcarskas, 1968), is claimed to have proved an "important breakthrough" in the treatment of certain psychoses (Welshman, 1999:209). The development of new drugs in particular was seen as very important by doctors. They presented them as effective treatments for psychoses, further developing medical influence. They at last had what was seen as an effective

treatment to use. In conducting further research on this issue, it then becomes important to explore conflicting accounts of the importance of new drug therapy in comparison to other approaches. This will include the possibility that heightened staff attention towards those receiving the new drugs may also have been very influential.

A debate over the actual efficacy of these new drugs in relation to the influence of other changes has continued since. It is important to continue assessing newly emerging evidence, as these issues have had implications in approaches to mental health policy in respect of the nature of provision. Effective drug therapy is one of the important factors in relation to community care for example. Oral evidence on this issue, which emerged from the research data, will be presented in Chapter Five.

Although new developments were taking place, particularly in the period following the founding of the National Health Service, there was still a failure to provide an integrated approach to the mentally ill that took account of both their clinical and social needs (Butler, 1993:31).

(14) The institution as a self contained community?

As the county mental hospitals lived on, similar in structure to feudal villages, they were not only communities within themselves, but also in relation to each other. Cricket matches and other sports became seasonal activities between institutions. Move from one institution to another, and the likelihood was that very little was different except in small details. Dances would be held in the great hall when male and female patients would have their only chance of socialising together (and then

only under the strictest supervision) (Scull, 1979:199). It is useful to examine how much common practices, and culture, were shared between different institutions and this question will be considered later in the results chapters.

There is evidence that work within institutions, although poorly paid, had certain advantages for those who carried it out it. This fact can be interpreted as influencing the nature of the communities within which patients lived for example. Evidence for this will be examined in the exploration of the data. For staff, including attendants (or nurses), there may have been lodging provided. Indeed, it was obligatory for many to live-in until well into the twentieth century.

The North of England, Wales and Scotland are identified by Gittins (1998:55) as being the traditional area of recruitment for nurses at Severalls Hospital before the Second World War. Also, during the time of the industrial depression of the 1930s, some recruits moved from areas of high unemployment to find work at St Crispin Hospital in Northampton, and were known to the author.

Among attendants there were many, throughout the service, who were highly motivated and tried hard to improve the lot of those under their supervision. The same can be said for many medical officers as well. However, problems appear to have developed during the period of the Second World War at St Crispin Hospital that led to a deterioration in standards of care. A poor general physical environment and a lack of availability of adequate resources are revealed (Archive Material, Northamptonshire Record Office and Oral Testimony). Other institutions harboured

problems that were sometimes later revealed in public enquiries. What contributed to these crises and how did they develop in effecting the communities involved?

Many problems may have been financial, particularly during the period of general privation in The Second World War. However, the idea that this may have been the most significant problem can be viewed as being too simplistic. As an explanation, it fails to take into account the varied experiences within different institutions and, critically, the roles of individuals within them. To understand the varied experiences of the inhabitants of institutions at this time (and later) and what remedies were applied, it is necessary to focus on particular hospitals and explore the circumstances and events. Evidence of the specific problems associated with the crisis in the post-war period at St Crispin Hospital in Northampton has emerged. This crisis and how the move away from it took place will be explored in Chapter Five.

(15) The beginning of the end: later developments in the institutions.

In the 1950s, the stirring of new, enlightened ideas in parts of the service have been argued as being enhanced by additional factors. These, it is said, produced what were seen as enormous changes at the time. One was the so-called "open door" policy that implied easier access to services for the mentally ill, a policy first initiated by the Mental Treatment Act of 1930 (Butler, 1993:37). However, developing a policy of "open doors" at actual hospital level was often much more difficult. Many acute wards, and wards for the elderly, remained locked and many still are. However, in some institutions, and in particular during the 1950s and 1960s, enlightened nurses and medical superintendents promoted a policy of open access. A minute of the Medical Advisory Committee at St Crispin Hospital taken in 1957 demonstrates

first, how doctors wished to retain control of this process, and second, how slow it may have been initially.

> "Resolved: -
> (1) 'That with a slight re-distribution of patients, wards 3 and 7 on the male side be unlocked by day'
> (2) 'That the main door at the entrance to the female side on the right hand side of main stores be unlocked by day'" (Archive Material, Northamptonshire Record Office)

Before such changes were implemented, it had been impossible to move from one unit to another without a key as is revealed in oral data from a St Crispin Hospital male nurse who had started work there just before the Second World War:

> *B. "...don't forget we all had bunches of keys, I mean anywhere was very secure, the wards were locked and so on and so on."*
>
> *B: "...but it was very, very difficult to take away from the situation that was so institutionalised, the locked doors, you know, the clanking of the keys and all this sort of thing..."*

A key, therefore, was not only an essential piece of equipment for staff but could also be perceived by patients as a symbol of power. This perception was described in the oral testimony of an ex-patient who was admitted to Napsbury Hospital in 1965.

> M. "*Who's got the keys? The person who's got the keys defines what is normal. It doesn't mean they're smarter or more right than anyone else, it's simply about who's got the keys... he who pays the piper picks the tune...*"

A patient known to the author at St Crispin Hospital in the 1970s referred to all staff as "them with keys". The perception by patients of their lowly position in the hierarchical structure of the institution, could therefore be defined by the power of access and egress, provided by that symbol of power, the "pass key". This perception of powerlessness could arguably sometimes be assuaged by verbal abuse or even

violence. At other times, acts of rebellion, resistance and possibly revenge took other, covert forms. In one instance known to the author, on a particular "male" ward, staff checked their teapot every time, before using it for a break. This was after an instance of finding human faeces within on a previous occasion. It was believed that a patient had carried out this act and one particular man was suspected. Staff and patients also used different coloured crockery at St Crispin Hospital, which was another expression of "differentness".

In addition, the element of "risk" created by the "lost patient", not just for him/her or the public in general but also for the unit or ward concerned may have been viewed as too great. The fear of formal inquiries and disciplinary hearings led very often to a cautious, "safety first" approach. How important staff led initiatives were, in attempting to change this culture, is worthy of further exploration. It is also necessary to understand how extensive and influential these changes were and whether factors other than the most often cited also contributed to progress. These questions will be examined in more depth, using original data, in the results chapters.

The introduction of the first phenothiazine group of drugs and especially chlorpromazine ("Largactil"), as described earlier in this chapter, is recognised by Jones (1972:291) as one of the "three revolutions" in provision for mental health. The others were the "open door" movement and the reform of the law resulting in the Mental Health Act of 1959 also discussed earlier. The 1953, Third Expert Committee Report on Mental Health of The World Health Organisation, described a "modern" system of which the mental hospital was but a part, rather than the centre

of, a community service (Jones, 1972:293). This report also reflected the fact that attitudes towards mental illness were beginning to change (Welshman, 1999:209).

Psychotherapy, and other "talking therapies" familiar today, originated in universities, and proponents were influenced initially by the work of Freud and Jung (Scull, 1979:258; Porter, 1987:214-215). Some practitioners identified with those who saw themselves as representing a reforming, progressive influence within hospitals. Experiments in "Therapeutic Community" living were also begun at this time in the period during and after the Second World War (Tucker, 2000:10). These too must be recognised for their relative contributions to the changing nature of mental health hospitals and communities.

(16) Conclusion.

Although initially there were areas of enlightened change in some large institutions, and although more outpatient clinics and day hospitals were being opened, many in-patients were untouched by these developments. As remarked by Butler (1993:3):

> "The legacy of the Victorian asylum and the nineteenth century policies on lunacy have proven to be remarkably resilient."

The above comment, written in the 1990s, is a long time after Enoch Powell as Minister of Health sounded what was supposed to be the death knell of the asylum system as long ago as 1961. However, by the middle of the 1950s, the origins of the services that would replace the institutions were in evidence. This included the beginnings of interest-related volunteer groups that would ultimately develop into service-providing organisations, such as MIND that now work alongside statutory services. However, recognition of these early voluntary services, developed in some

institutions, is lacking in much literature dedicated to the history of mental hospitals, and is an area that requires further examination.

In Chapter One, we have briefly outlined the history and development of what are now termed mental health services, from integration of individuals within local rural communities, through periods of confinement under the Poor Laws, institutionalisation under the Lunacy Acts and Mental Health Acts, in asylums (later mental hospitals) and medicalisation, to pressures against institutional confinement in the latter part of the twentieth century.

The history of mental health and social policy outlined above would seem to suggest that changes on modes of governance of those we now refer to as having mental health problems cannot be understood solely in terms of enlightened progress. The incarceration of the so-called "dangerous individual" in the asylum isolated such people both geographically and socially and this is arguably the origin of the local community based around geography and occupation that will be described in Chapter Four as the "Geographic-occupational Community". The role of the medical profession in overseeing this incarceration helps us to anticipate the nature of that geographic and occupational community. In the time before the development of psychiatric knowledge, the medical profession's legitimacy was through the execution of a type of social role rather than based on therapeutic effectiveness. Their role was akin to that of the squire, a type of benevolent authoritarianism that exercised a patrician regime of rewards and punishments within a strongly hierarchical structure, at the bottom of which was the patient. This, with an expectation of the acknowledgement of his authority reflected what was, in many

ways, a more deferential age. Within this authoritarian structure, what would today be termed as the potential risk presented by some mental health patients was managed.

This began to change, at first, in the mid 1930s and then, in the 1950s, after the deprivation of the war years, with a surge of therapeutic optimism. The changes that wrought these events included the founding of the National Health Service in 1948, and new attitudes towards the treatment of the mentally ill. Doctors could no longer claim dominance on the traditional basis described above and retained legitimacy through a concept of mental illness being on a par with physical illness, and then with their perceived ability to provide new and effective treatments. The changes in hierarchical patterns have implications for how we conceptualise community, risk and therapeutic activity in mental health care.

Chapter Two will examine theoretical concepts of community in the context of mental health policies and explore their influence both on a national and on a local basis.

CHAPTER TWO

CONCEPTS OF COMMUNITY

Introduction.

This chapter comprises a brief review of literature relating to conceptualisations of the nature of community. The review begins with an examination of what is understood by the term "community". It will focus on perceptions of community and the way these perceptions have been reflected in mental health provision in the development of service structures, as well as wider social effects. The review will proceed from a historical perspective in examining theories of community. Specific aspects will be explored in the following order:

(1) What is understood by the term "community"?

(2) The "individualistic" tradition.

(3) The "communitarian" tradition.

(4) The Industrial and Agricultural Revolutions and the development of social classes.

(5) The institutional ideal.

(6) The geographically and occupationally defined community.

(7) Community as a place of choice and belonging.

(8) The word "community" in mental health and social care policy-making.

(9) Care in the community.

(10) Conclusion.

The scope of the available literature will be considered first.

(1) What is understood by the term "community"?

The word "community" appears frequently in a wide range of policy and other literature and in particular, in relation to social policy and health care. In addition to ethnicity, law and order and other areas, the word has become very closely linked with current government-inspired social and health care policy, including "care in the community".

Much has been written on the conceptualisation of community. The word is defined in a number of different ways and does not appear to have one clear, accepted definition. It is recognised that the concept of community is "complex", abstract and "usually unanalysed" (Minar and Greer, 1969:ix). It must also be seen as context specific. However, two major traditions in the conceptualisation of community have emerged and are noted by Plant, (1974):

* The "individualistic" tradition.
* The "communitarian" tradition.

(2) The "individualistic" tradition.

An example of the individualistic tradition is that propounded by Rousseau who cites the idea of a social contract whereby, from the merely personal, humanity could move to "nobler" feelings of care for a broader society. The result would be an unselfish view that would reflect higher moral feelings among citizens.

"This formula shows us that the act of association comprises a mutual undertaking between the public and the individuals, and that each individual, in making a contract, as we may say, with himself, is bound in a double capacity; as a member of the sovereign he is bound to the individuals, and as a member of the state to the sovereign. But the maxim of civil right, that no one is bound by undertakings made to himself, does not apply in this case; for there is great difference between incurring an obligation to yourself and

> incurring one to a whole of which you are a part." (Rousseau, 1966 [1762]:13-14)

This would involve the individual giving up "original" liberty (O'Hear, 1985:285). The English philosophers Thomas Hobbes and John Locke, argues O'Hear (1985), shared with Rousseau the notion of such a contract between the citizen and the state whereby, in exchange for protection, internal and external, allegiance is owed to a sovereign.

Hobbes (1955, [1651]:107) believed social solidarity to be obtained by the notion of "representation" whereby many men are made one by representation by one man. In respect of individual rights, he comments that

> "...the right of all men to all things, ought not to be retained, but that some certain rights ought to be transferred, or relinquished. For if every one should retain his rights to all things, it must necessarily follow, that some by right might invade, and others by the same right, might defend themselves against them, (for every man, by natural necessity, endeavours to defend his body, and the things which he judgeth necessary towards the protection of his body)." Hobbes (1982 [1588-1679]:33),

The notion of a contract, whereby a compromise is reached between certain levels of individual liberty in exchange for protection by the state, was felt by Hobbes to be the only practical solution. Hobbes (1651) further wrote that the sovereign representative could not carry out an injustice to a subject because every subject is "author" of any act of a sovereign. The only right of the subject is as the subject of God and is therefore bound by the laws of nature. In other words, in exchange for a degree of protection, the subject had abrogated his rights to a sovereign representative and provided them with unlimited power. Any injustice would therefore be an offence to God and not to the subject. A problem with this argument is that the subject does not always have a choice as to the granting to the sovereign

representative of unlimited power. The state as incarnated in the "sovereign representative" can therefore act in a way that totally ignores the interests of individual subjects or the possible justice of their cause. This may be in a way that protects the power of state institutions. It might also include, for example, the sacrifice of the liberties of some as protection against civil unrest among the many, as well as direct threats towards itself or its interests.

Protection for the citizen, it could be argued, may include the incarceration of those deemed "mad". Foucault (1967:38) discusses "the great confinement" in seventeenth century France. Foucault portrayed issues surrounding "the dangerous individual". What is today termed "risk" in respect of potential aspects of behaviour that may be exhibited by those deemed mentally ill is still of prime consideration today as it was during the so called "great confinement" in France. The institutions of England and Wales also exhibited, as will be described, characteristics that implied a design of physical structure and operation focussed on managing risk. Later in this chapter and in the results chapters, the issue of risk and how it was, and is, managed in its various forms will be discussed. Chapter Five will explore the issue in depth and bring it up to date.

Entry into the world of the mental hospital and isolation from the rest of society was usually compulsory (King, 1991). This has been so until relatively recently. As we have seen in Chapter One, the Mental Treatment Act (1930) made other forms of admission possible. This was under two categories, as a voluntary patient, or for "temporary hospital care" (Butler, 1993:27). Compulsory admission was retained however as a medical option. There is evidence, for example in case notes at Friern

and Claybury hospitals, that a minority of patients did seek voluntary admission (Tomlinson, Carrier and Oerton, 1996:124). However, there would be no consensual social contract for the mentally ill generally. They were, and often still are, excluded without choice.

(3) The "communitarian tradition".

The communitarian tradition is based in the social and political theory of the late eighteenth and early nineteenth centuries particularly among the German philosophers such as Herder, Schiller and Hegel. Marx in particular acknowledged Hegel as his major philosophical influence.

A driving notion behind the communitarian tradition was one of a rediscovery of a concept of community that was believed lost, the "Polis" of Periclean Athens (O'Hear, 1985). The "Polis" was considered the ideal of a community based on homogeneity (Plant, 1974:16). It was taken as a paradigm, in terms of which criticism could be levied towards what could be seen as the atrophied character of social life in Western Europe, in other words, a form that had lost its vigour. In Britain, such idealism is rooted in the thinking of utopian socialists such as Robert Owen. Paradoxically, it is also linked to what may be seen as "conservative" and more traditional sociological approaches associated with Tonnies and to some lesser degree, Durkheim (Hughes, 1996).

The fact that "lost" community is nostalgically harked back to cannot be taken as evidence that it did indeed ever exist in the form that is imagined. This still does not, however, lessen the power of the concept when it is posed in contrast to the

problems of modern post-industrial society (Cohen, 1985). The difficulty that exists in understanding the past is reflected in changes in the human condition and this must be taken into account in trying to understand previous concepts (Tosh, 1984). Historicism, that is the tendency to interpret the past in terms of its inexorable contribution to the present, is bound to intrude in any related research.

O'Hear, (1985:277) poses the possible permanence of the loss of a community perspective engendered by the loss of the city-state and of the loss of other social organisations providing cohesiveness. Communitarian concepts visualise individuals related in interdependencies with qualities of mutual help and trust. Symbolic significance in the culture of group loyalties takes precedence over individual interests. Etzioni (1995:12-13), does not see Communitarianism as being based on the views of majorities. Equally, communitarianism can encompass different shades of political opinion.

> "Communitarians are not majoritarians. The success of the democratic experiment is ordered liberty (rather than unlimited licence) depends not on fiat or farce, but on building shared values, habits, and practices that assure respect for one another's rights and regular fulfilment of personal, civic, and collective responsibilities. Successful policies are accepted because they are recognised to be legitimate, rather than imposed. We say to those who would impose civic or moral virtues by suppressing dissent (in the name of religion, patriotism, or any other cause), on censoring books, that their cure is ineffective, harmful and morally untenable."

Etzioni (2004:21) accepts that an individual may be linked "with several communities. He considers them necessary for each individual;

> "...communities are essential for our full constitution. We can survive without them, but we can neither achieve nor sustain a full measure of what is considered a 'fully functioning' human being without some measure of community. And thicker communities bode well for our constitution, although excessive community causes ills of its own." (Etzioni, 2004:20)

Burkitt and Ashton (1996:14) discuss communitarian ideas within the concept of new, socially inclusive social relationships as expounded by Etzioni (1988). A "stakeholder economy" reflective of neo-communitarian ideas propounded by "third way" politicians has reflections of this ideal. The way that "community" is broadly used as a term for "good" in relation to mental health policy could be considered a reflection of this broad concept.

The concepts expounded within communitarianism could be interpreted in a micro sense as being reflective of the ideal traditional mental asylum such as "The Retreat" founded by the Quaker, Tuke at York referred to in Chapter One. The Retreat comprised a residence within a humane and congenial environment coupled with moral management:

> "...a coalescence of humane asylum treatment and a distinction between the psychological (moral) and biological (physical) causes for the purpose of correct treatment plans and possible cure." (Arieno, 1989:70)

The aim of the Retreat was to be part of a largely supportive interdependency, and this ideal maps convincingly on to the ideal of community espoused by communitarian thinkers.

Nostalgic views of the subsequent development of large mental hospitals on a national basis are contained within some historical accounts. They are sometimes written by ex-staff and to this extent could be seen as biased. They may take a largely descriptive form, accepting evidence uncritically. Thus, although the communities are described, they are not well explored in relation to their nature over time. There is therefore a gap in the knowledge relating to theoretical conceptualisations of community in mental health. The changes in mental health

policy leading to community care are noted by Butler (1993:3) as reflecting a series of "complex and powerful shifts and changes both in society and in the policies established by successive generations." Butler stresses the importance of situating such changes in their social context in order to understand them. Failure to do so, he argues, results in the misuse of history in order to justify current policy and practice, or else an "unintelligible collision of beliefs and approaches." Butler also identifies the current tendency to consider the community and institutional care as polarised alternatives, when the situation is far more complex and he examines some of the stereotypical notions of each. Detailed work on this issue with the involvement of the individuals actually involved, the staff and patients, in the formulation of theory of community is lacking.

Perring (1992:131) identifies the vague nature of the word community itself that gives it the power to be "all encompassing" but always with a "positive symbolic value". Perring (1992:131) also states that influence on the model of community care used in the closure of Cane Hill Hospital was that of a "bounded community" reflective of "kinship and connectedness" based around group homes. She notes that this is comparable to the model of the asylum-based community while neglecting the issues of "power differentials" based around factors such as gender and generation. The need to attempt to clearly define origins of the changes and potentially some of the myths of the move from hospital to community care, accessing those individuals who experienced both worlds, is important, if a better understanding of current policy and practice is to be developed. This includes considering those involved in establishing early hospital voluntary services as well as professionals and ex-

patients, an area already identified in Chapter One as neglected in dedicated literature.

(4) The Industrial and Agricultural Revolutions and the development of social classes.

Ferdinand Tonnies (1963 [1887]), discusses in "Gemeinschaft und Gesellschaft" the effects of the height of the industrial revolution in Germany on the notion of community. For Tonnies, "Gemeinschaft" is descriptive of community in the coherent, fixed and idealised traditional sense and "Gesellschaft" refers to the relationship of the "contract and not habit or customary observance". The authority of a society of this second nature cannot be seen as being based on the development of traditional practice but rather based upon quite the opposite:

> "...the legal, rational notions of consent, volition and contract, a view which implies a radically individualistic account of the genesis and authority of the legal order." (Plant 1974:23)

Durkheim was also influential in conceptualisations of community. In "Suicide" (1897 [1952]), he conceived the notion of "anomie". Berger and Berger (1976:38), describe this as a condition by which there was "a state either of individuals or of groups, in which there is a lack of solidarity or social ties". This condition, reflective of the atomising and divisive effects of modern society, is seen to result in conditions of unhappiness and stress leading to a raised incidence of suicide. Durkheim (1947 [1964]) in his text, "Division of Labour in Society" also conceived of other factors of influence on social relationships – "mechanical" and "organic" solidarity – "altruism" and "egoism". To Durkheim, "solidarity" represented the nature of the relationships between people. "Mechanical solidarity" represents total social relationships as would be found in tribal society, for example. With the

coming of capitalism, social ties are changed by the increasing complexity of the division of labour. "Organic solidarity" represents a society in which the relationships are less bound and committed. Durkheim argued that a moral entity of "collective consciousness" developed as people mixed, influenced their behaviour. Cuff, Sharrock and Francis, (1992:29) defined this as a factor that "obliges them to behave in particular ways" From this perspective, the position of the mentally ill in a society moving towards an increasingly "organic" manifestation as capitalism developed, could be seen as inevitably subject to a new gaze.

The mentally ill have been seen as victims of social tension, hence the use of the name "asylums" for early mental hospitals. In respect of past mental health practice based on institutional care, the community outside hospital appeared to place individuals with mental illness or handicap on "probation". Their "natural home" was seen as the hospital (King 1991:42). There has been limited research exploring the nature of interdependent relationships within the old institutions and indeed with the local communities with whom they interacted for so many years. It will therefore be important to examine any insights into these areas that emerge from the research data.

As recorded in Chapter One, members of the industrial working classes were usually originally from rural environments, moving to towns and cities in order to seek work. The old "domestic system" where whole families worked together in the home within smaller social groupings broke down. Members of families no longer necessarily worked together or with their neighbours. These changes were allied to rural poverty and population growth. The "industrial and agricultural revolution had

some most unhappy effects on society and on the amenities of life in village and town" (Trevelyan, 1942:344).

It was at this time that the system of administering "pauper lunatics" began to be developed on an almost industrial scale. It is however important, before examining the major changes, that those identified as having mental deficiencies experienced during this time, to consider what the nature of the rural community itself was. There is evidence that it was in fact characterised by oppressive hierarchies, exploitation and division.

Although the living conditions of the emerging working class in the industrial towns and cities were often very poor, there was often also severe rural poverty as well. The rising price of food and in particular bread, during a period when Britain was cut off from the grain markets of Europe during the Revolutionary and Napoleonic Wars from 1793 to 1815 added to rural poverty. Newby, (1987:29) comments that earlier, the "Purchases of bread, which had accounted for 44 per cent of total family expenditure in the 1760s, constituted 60 per cent by 1790." In addition, a result of the emerging wartime economy was the effect of speeding up the changes brought about by the Agricultural Revolution (Newby, 1987). This promulgated change in the nature of the rural community. In commenting on the concept of the bounded and supportive rural community, Newby (1987:89) states:

> "There were many English landowners who tried assiduously to cultivate this idealized 'community' in their own locality; some were brought up in the midst of it, and, safely cocooned by wealth and residence, actually believed in it without realising the less congenial reality that lay behind it. They may even have been reasonably successful in transmitting their ideal from time to time to those who found some sense of personal security in it."

The "traditional" social composition of a village community has been conceived as being composed of a squire, a parson and associated parishioners of particular influence such as churchwardens, farmers, blacksmiths, innkeepers and other tradesmen. In addition, there would possibly be one or two families of independent means who would socialise with the local gentry. Jane Austen based her novels such as "Mansfield Park" (1814 [1966]) and "Emma" (1816 [1969]) within such small social groups. The gentle lifestyle portrayed and parodied in these novels contrasts strongly with the lot of the lower orders. At the bottom of the social pile were farm labourers who may move in and out of lesser or greater poverty depending on the fluctuations of change. During old age or because of ill fortune, unemployment, accident or illness (including mental health problems) they could fall into pauperism and be the recipients of charity from the parish. The pressure for conformity was strong, as the danger of a fall into poverty was constantly present and in particular, if social norms were not followed. The Reverend Richard Cobbold (1977 [1860]:147) in his portrait of the inhabitants in Wortham in Suffolk identifies one man who fell socially due to "drink", which was very much a general concern:

> "Francis Groom was clerk of the parish for many years and his son George succeeded him. They were both carpenters and though, when sober, were excellent workmen, yet both had that dreaded fully debasing propensity to drunkenness which destroyed the peace and happiness of the Old Man's life and brought his son to a premature death.
> Francis Groom was compelled to go to the Union House from which place he was taken by his grandson Henry Potter. Francis died a penitent May 2nd, 1849."

The status quo of rural life was also enforced by draconian laws as well as social pressure. These include those against poaching from landowners. Another way in which the labouring poor expressed their struggle and was a capital offence under the so-called "bloody code", (Cowley, 1998:147) that lasted for over one hundred

years, was "rick burning". Capital punishments carried out in Northamptonshire are recorded:

> "...the other three men were all hung within the 15 year period of 1819 to 1834, which is highly significant. Rick burning, or incendiarism as it was called, was particularly prevalent in the early 19th century, as it was one of the few ways that the labouring classes could draw the authorities' attention to the extremely depressed state of agriculture, when farm labourers' wages fell to 9d per day." (Cowley, 1998:38)

The evidence shows that the rural community was not always an idyllic place in which to live, but uncertain and potentially cruel. The class divisions were rigid and maintained under the strict penal code referred to above. Likewise, the mental institutions were governed under a rigid hierarchy with the medical superintendent at the pinnacle. Perceived risk emanating from the patients was managed by strict containment, constant observation, discipline and work.

The general concepts of early idealist philosophers are identified by Cohen (1985), as being reflective of influences favouring a return to greater social control. In a broader sense, politics itself may be seen as:

> "...essentially destructive of the ties of sympathy and common purpose that can bind men together." (Shils and Young, 1970:222)

Examining the division of social classes is certainly important in any attempt to develop an understanding of concepts of community in mental health. Apart from the differences of class between patients in state and private charitable institutions, there also may have been significant divisions between patients within any institutions. This also applied to divisions of class between staff members. For example, there were undoubtedly differences in social class between many Medical Superintendents, who were usually from middle class backgrounds, and other staff,

or between some nurses, artisans and voluntary helpers. In addition, class divisions between patients within and between hospitals are little evidenced in the extant literature except in terms of a "private" or legal "formal" or "informal" status. These issues will be considered next.

Goode (1969) explores the concept of "communities within communities" Applied to mental hospitals, this could refer to the position of professions such as the medical profession. Within institutions, including mental hospitals, the divisions are revealed as widespread, with clear hierarchies (Orme and Brock, 1987). The social structure of the old asylums largely survived until the end. The nature of the relationships between individuals as influenced by hierarchy and social class, both staff and patients is under-researched.

In the newly emergent asylums, the social hierarchy can be interpreted as reminiscent of an idealised rural community. All of the above stereotypical roles of squire and parson, tradesmen and labouring poor can find their equivalent in the mental hospital community. An ex-member of staff of St Crispin Hospital, "C", in oral testimony even referred to hospital and village as the same:

> *"... it was the fact that apart from the skilled people the engineers and the...and the carpenters and tailor and shoemaker and all these other people who were part of the community...part of the village...in those days the attendants did mostly everything else..."*

The superintendents certainly lived in squirearchical splendour. As already noted in Chapter One, Dr Wing of Northampton General Asylum in Northampton had a coach and horses, as did the medical superintendents at Northamptonshire County Asylum and others elsewhere. At the county asylum, the superintendent also had a

relatively large house in the grounds. Each hospital would also have a church or chapel in the grounds with an incumbent or visiting priest or priests. In addition, there would be a hospital farm or other industry on which some of the patients would work. Some may also have acted as servants for staff. Each hospital had its own tradesmen who would often be assisted by patient labour. Within the hospitals, staff gradually became unionised. At St Andrew's Hospital, The Confederation of Health Service Employees (formed after the merging of The Mental Hospitals and Institutional Workers' Union and the Hospitals and Welfare Services Union in 1946 (Carpenter, 1988:135), "was long refused recognition by the Management Committee despite pressure from other unions." This policy was finally reversed in May 1946 after the committee was persuaded to agree to a ballot that showed 225 in favour of recognition as opposed to 102 against. A stipulation of the Management Committee had been that the vote must be "counted by Sir Kenneth Murchison and Sir Wellwood Maxwell" (Foss and Trick, 1989:261).

At St Crispin Hospital, there was a longer history of union activity. There is evidence that some aspects of even this activity could be subtly reflective of social divisions within the institution. The hospital contained an "Officers Branch" of the Confederation of Health Service Employees that was formed on May 17th 1956 (Privately owned archive material). This branch was an addition to a previously existing, general, "Berrywood Branch" of the union. Membership of this new branch may have extended to at least one member of the medical staff. Minutes for the monthly branch meeting on 20th August 1956 record:

> "Result of circular letter sent to 40 non-members employed at the hospital. The secretary reported that 10 replies had been received. Mrs X. ---- had joined as a result and Dr Y. ------ had asked for an application form." (Privately owned archive material)

Although no rationale is included in archive material for the formation of an additional "officers branch" it can be speculated that it was intended to protect the interests, and to promote concerns, of the more senior hospital staff that it was felt could not be best dealt with in the general branch. One entry, for example, concerns correspondence sent to a bus company in respect of "the withdrawal of certain buses to and from the hospital gates." (Privately owned archive material) Another deals with the pay differentials of senior nursing staff. It also had the effect of separating the officers from more junior staff at a time of rising militancy among mental nurses.

In discussing "the lean years, 1952 to 1959", Carpenter (1988:291) comments:

> "The discontent beneath the revolt of mental nurses ran far deeper than simple dissatisfaction over rates of overtime pay, or even pay and staffing problems. Against the background of overall neglect changes were taking place in the apparently ordered world of the mental hospital, fracturing the timeless and self-contained community with its firmly defined hierarchical relationships. The uncertainty created by these changes added to the problems experienced by nurses, and formed an important background factor to their militancy."

In addition, also active in St Crispin were various unions for artisan staff. Nationally, in general hospitals as well, Carpenter (1988:286) in a comment that would apply well in understanding the formation of the St Crispin Officers Branch remarks on COHSE being:

> "...squeezed on nurses by the RCN, on ancillary workers by NUPE and the TGWU, on administrative staff by NALGO and on laboratory and professional staffs by the Association of Scientific Workers (later ASTMS). Instead of responding to COHSE's campaign for industrial unionism, health workers were increasingly organising on the basis of grade."

The portrait that is painted is of a diverse, hierarchical and almost industrial community.

For patients, there were statutory bodies such as the Mental Health Commissioners. There was no independent representation, until organisations such as MIND were

founded. The role of such voluntary organisations is under-explored in respect of their effect on individual institutions. It is important to understand and identify a theoretical explanation of the nature of these communities in the crisis of change if the subsequent development of mental health services is to be properly understood.

Social class was also influential in other respects within some institutions. There is evidence that there were divisions within the patient group. The Borough Asylum in Northampton, which had been the town's first facility for the mentally ill, had a long history of aristocratic patronage and was to remain outside the National Health Service as St Andrew's Hospital after 1948. The majority of its residents were fee-paying private patients, although some were resident on a charitable basis. In respect of the experiences of residents, Foss and Trick (1989:180) refer to a decision in 1882 to "convert the Moulton Park farmhouse into a residence for second-class male patients, who could help in the farm work." Initially, the county asylum at Berrywood in Northampton also took in private patients. An attempt to transfer some of them, "who would be better placed" to St Andrew's in 1896, as well as a number of pauper patients, "on terms lower than the minimum rate" was initially resisted. This was;

> "...partly because it would be against the provisions of the 1890 Lunacy Act, partly because some of the patients were chronic and their acceptance by St Andrew's therefore against the recommendations of the Lunacy Commissioners, and partly because there were no vacancies." (Foss and Trick, 1989:199)

The situation was eventually resolved by the Visitors to the county institution (later St Crispin Hospital), being invited to send in, through the patient's relatives, applications for admission at rates lower than the minimum for consideration "on merit" and as vacancies occurred. Why those patients were considered more suitable

for treatment at St Andrew's is not revealed, but this incident came during a period when the Northamptonshire County Council had been attempting to wrest control of St Andrew's from its governors and develop a combined service with the county hospital at Berrywood. In this, as already noted above, they were to be ultimately unsuccessful.

(5) The institutional ideal.

The reformers who were responsible for the building of new asylums demonstrated an intention to show the superiority of their system over what had gone before. To many of those entering as patients, the contrast in conditions and the splendour of the buildings must have been impressive in an age when even water closets were the preserve of the relatively well-off. To these factors were added the claims of expertise in managing and seeking a cure for the mentally ill by the asylum doctors. Scull (1979:94) cites Hill (1839) in commenting:

> "Only a purpose-built asylum could provide the requisite conditions for 'moral and physical management...as well as the means of preventing personal injury and inconvenience to the patient.'"

There was certainly some improvement in conditions earlier in the nineteenth century for individuals who were considered to constitute a particular risk by their local communities. When Northampton General Lunatic Asylum was opened in 1838, Jenkins (1993:234) comments:

> "The concern expressed for the 'comfort and privacy' of the inmates must have surprised anyone who witnessed the removal of the 'insane', chained and manacled, to the new asylum from the old lock-up in Fish Lane, Northampton (later Fish Street). There they had been chained to the floor where they lay in straw."

At this time, perceived risk provided by the potentially dangerous individual was contained by means of incarceration and isolation. The management of risk was

contained within the gates of the institutions and any violence that occurred was usually directed at others within, such as patients or staff. The issues surrounding changes in the management of risk are under-researched with regard to the historical development of mental health services with the demise of the large institutions. The subject will be explored in Chapter Six.

Often impressively built, usually on rising ground at the edge of towns with beautiful gardens and prime working farmland, the new edifices were usually too big and crowded to allow the more progressive approaches to care that were espoused. These were usually based on the "moral treatment" of "The Retreat" at York as noted in Chapter One. Although it has been shown that the institutions contained divisions reflective of the community at large, the identification of positive features can be speculated as being neglected in the moves to close them and move on. They had become "old fashioned" as a concept and felt to be as reflective of bad policy as they were once seen as the way forward. Jack (1998:24) makes the point:

> "The anti-residential care movement, in its narrowness of focus, tunnel vision and over-reliance on rhetoric at the expense of scientific rigour, has the characteristics of zealotry and ideology. Rhetoric has proven more persuasive and enduring than reason in promoting the abandonment of this form of care and for the persistence of bias among the helping professions"

This "zealotry", from the perspective of Jack (1998:29), is also "evidenced by its blind assumption of the existence of a 'community'" to which patients could be discharged. It is important to understand the extent to which the asylums had positive features, perhaps more usually associated with the ideal rural community. These issues are under-investigated.

The arrival of new asylums, usually in small rural communities on the edge of centres of population must have had a profound impact on those villages with which they became associated. They must, for example, have become major employers. Whether the asylum activities in the local surrounding community compensated for some of the lost amenities of village life to which Trevelyan (1942) refers is worthy of further investigation. For example, as well as providing a source of employment, little is known of the level of interaction between the hospitals and the communities local to them. A common perception is provided by Gittins (1998:29), already noted in Chapter One, who talks of the hospital gate as "the boundary between two distinct communities". It is important to determine whether these beliefs are in fact as true as has been claimed.

Figure One: Duston, Northampton in 1874 – Two years before St Crispin Hospital was built.

In contrast to Gittins (1998), it seems that, as time passed, the asylum community at St Crispin Hospital and the local, initially rural community seem to have become interpenetrable. This would represent a new way of viewing the relationships

between mental hospitals and the communities local to them. This issue will be examined further in the results chapters.

(6) The geographically and occupationally defined community.

The dynamics of the relationships between the excluded (and the excluding), i.e. the patients and staff within mental hospitals, often known only to the involved individuals, is still largely untapped and needs further exploration. Whether those who populated the hospitals felt socially excluded as well as physically excluded within the gates has not been examined in depth. It can also, conversely, be argued that living outside an institution does not necessarily lead to social inclusion. Gittins (1998:29) comment of the gate of Severalls Hospital marking "the boundary between two distinct communities" needs to be examined further. The extent of any interactions and the nature of social exclusion (or inclusion) of the mentally ill within geographical communities has not been extensively explored.

Fricke (1973), in considering seafarers and community, describes a complementary division of labour, an "occupational community", within a particular area, as a sub group within a larger group or groups. Belonging, as part of a community, involves shared activities demanding an interrelationship of effort, shared culture and is within specific locales. Conversely, Minar and Greer, 1970:140), in considering a community based on "function", discuss the tendency of occupational specialisation to "pull out" individuals from interaction with their neighbours. "Thus the factory, the trade union, the corporation structure, the profession become communities bound together by shared function rather than shared space." Such factors are reflective of a number of industrial activities and the theoretical concept of the "occupational

community" has not been adequately explored in respect of mental hospitals during the first half of the last century.

Tosh (1984:147) in the context of historical relativism argues that:

> "We can never recapture the authentic flavour of a historical moment as it was experienced by people at the time because we know what happened next; and the significance which we accord to a particular incident is inescapably conditioned by that knowledge."

However, accepting that interpretation is influenced by the gaze of the researcher, detailed theoretical work influenced by the recall of individuals directly involved, is only weakly represented within the literature in respect of mental health. Such material does exist however (Glen, 1974; Barham and Hayward, 1991), though there is little material from individuals who were long-stay patients. In respect of the ex-mental health hospital patient, our understanding:

> "...is still to a considerable extent shrouded in a discourse imposed from above." (Barham and Hayward, 1991:3)

In understanding theories of community in respect of mental health, the voice of the ex-patient must not be excluded in the same way that a degree of broader social exclusion was forced upon them by incarceration.

(7) Community as a place of choice and belonging.

Gittins (1998:30) mentions a belief that "most people" living and/or working within Severalls Hospital "had a definite feeling of belonging." Skidmore (1994) argues that communities are personally defined. Communities depend on creation and construction taking place because of the wish of the members of such putative communities to do so. This is a theoretical perspective that, while reflecting present

approaches to community care, does not fit easily with long term involuntary incarceration where there is, or has in the past, been no element of choice:

> "Care by the community does not necessarily mean enlisting informal carers to carry out the role of the professional. In essence, care by the community is the transference of the responsibility of care into the client's world. That may mean using the client's network or self-care by the client. Remember communities are personally defined. It does involve empowerment and almost total withdrawal by the professional." (Skidmore 1994:104)

This perspective reflects more comfortably the "person specific" policies of modern individualised care and is far from concepts of community reflecting the systematised, depersonalising, institution centred and involuntary patient care policies of the past described by Goffman (1968). As Skidmore goes on to say:

> "Central to this discourse is the notion that 'communities' are highly personalized. They exist in as much as a person wills them to exist, as part of that person's construction of reality. The professional cannot make the assumption that it does exist. Being individual some persons may decide that it does not exist. Skidmore (1986) found this to be the case with friendship, albeit in a minority of subjects. The same could be true of community and this will have implications for how the person is treated. This cannot be revealed without entering into dialogue with a client." (Skidmore, 1994:107)

Other concepts also include the notion of the importance of individual experience.

That "community" does not exist in a specific outside sense but is;

> "...the immediate social context of the individual's life. Or, if one wants to put it this way, the context of which the outermost limits are what may be *personally* experienced or encountered by the individual in his everyday life." (Berger and Berger, 1976:120)

Features of social life defined by the word "community" may include: "…a sense of belonging, to shared cultural and ethnic ideas and values, to a way of life opposed to the organisation and bureaucracy of modern mass society, etc" (Plant, 1974:13). However, such social constructionist perspectives of community, as well as the work of Gittins (1998:30), who talks of most peoples feelings of "belonging" as being the

sense in which she refers to Severalls hospital as a community, again lack a consideration of the often coercive nature, under mental health detention orders, of the entrance of patients into the institutional way of life. Goffman (1968) describes "threats of punishment and penalty" to induce the cooperation of patients. Patients detained within an institution could therefore be argued to represent a challenge to the concept of a community of choice, feelings of belonging or personal definition. This raises the question of whether mental hospitals and their environs could be seen to have been communities. If mental hospitals can be argued to have been at the centre of cohesive communities, the personal choice definition can be seen as weaker in respect of understanding institution-based mental health services. If they were not, the concept of community as an act of wish fulfilment and personal choice would not appear weakened. In addition, from this individualised perspective, it could be argued that "community" would only be found within the institutions, be moulded by rules and regulations, the degree and nature of individual social interaction, and be more a personal thing. This would not preclude the notion of "therapeutic community" work within hospitals departments for example as will be examined in the next section. These general concepts will be further explored in Chapter Five in light of evidence emerging from the data.

(8) The word "community" in mental health and social care policy-making.

Community is defined in a number of different ways and does not appear to have one clear, accepted theoretical definition. It is recognised that the concept is complex, abstract and "usually unanalysed" (Minar and Greer, 1969:ix). In developing theoretical explorations of what constitutes community in mental health,

the evidence revealed within the literature is that it is easier to identify influences on community than to describe what it is.

A more specific definition of the term as used in mental health refers to the concept of the "therapeutic community". Tucker (2000:27) defines community:

> "In a sense, community is everything which dialogue, dwelling and care create. It is what is created when a person takes seriously the fact that making sense of themselves and finding meaning in their life occurs in dialogue at the point in contact between themselves and others."

This concept of a therapy that was popular as an enlightened approach to mental treatment from the 1950s was, usually, institution based. A constructed community, in the way individuals interacted within it, could in itself be seen as a therapeutic tool. In examining community care as a socio-political policy, Tucker (2000:15) considers that:

> "Integrating psychologically distressed people with other people and being part of a larger social group is of some value, both for the distressed and the other people."

From the perspective of Tucker (2000), the meaning of community care is taken to be that the community of those designated mentally ill are being cared for, albeit in a situation where they are not isolated behind walls and are mixing in general society. The notion is still one of the community as a therapeutic tool but in this case the members of it could be seen as sometimes being members of a more focussed smaller group and not necessarily broader society.

Early initiatives that began the evolution of alternative, "communities of interest" within institutional care and were inspired, in particular, by the opening up of some institutions to outside gaze (by such as voluntary groups) have been very sparsely

documented. These omissions represent a further gap in the knowledge base that this thesis will seek to address. The theoretical concept of the "Community of Interest" will be explored in Chapter Five.

Being outside hospital, however, does not necessarily mean social inclusion, nor does being inside hospital necessarily imply social exclusion. It will be important, therefore, in examining data, to be cognisant of the extent to which notions based around communities of interest within mental health may cut across the usual conception of a hospital-community divide. This seeming contradiction will be discussed next.

(9) Care in the community.

The subject of outside community living not necessarily equating with social inclusion is important in respect of current mental health policy. Does social inclusion necessarily require living out? It may be argued that hospital, institutional care, was not totally the opposite of community care in all senses. Was there not contact with the world of other people?

It is important to develop an understanding of this concept of community and its origins in relation to current policies. The use of a benign term, "social inclusion", which very few would reject, is important for government in particular. However it is necessary to understand the ramifications of the development. In terms of degrees of social contact and acceptance of the mentally ill by their neighbours, has much really changed since the days of the institutions? This is a subject that has not been much explored.

From a mental health perspective, it could be argued that the end of incarceration in hospitals for the majority of those deemed mentally ill, has led to policies believed to increase social inclusion. However, Foucault (1967), in studying the influence of power in society, argued that a social base defines itself partly by those it deems deviant, confines and excludes. This includes those deemed mentally ill. Barham and Hayward (1995:143) assert that having first been forcibly excluded, the mentally ill were then forced back into the community. Furthermore they point out that that inclusion is not synonymous with integration. This issue highlights contemporary problems of care in the community that can be partly understood by exploring the origins of services and the nature of the communities within which they operated.

In Chapter Four, evidence will be explored relating to the inclusion at St Crispin Hospital of patients, not only into a viable hospital community but into some activities of the broader, "outside" community surrounding the hospital. Conversely, there is the danger of individuals who are suffering or have suffered mental illness, living lonely isolated lives, or lives separated from wider society, following the development of policies of community care. McCourt Perring (1993:177) researched the establishment of group homes as part of a rehabilitation programme associated with hospital closure. She describes the limited view of rehabilitation conceived by carers, it being inward looking focused on a group home or within "psychiatric facilities", with few expectations of integration with any wider society. A major influence in this respect were the views of the providers of care themselves whose

> "…views on integration are relatively pessimistic – because they feel the resident has a permanent pathological condition and because they believe society is too intolerant and inflexible to accommodate such a condition – their idea of the community is an almost exclusively psychiatric one. Progress

> therefore, is a matter of 'getting on' and leading a reasonably contented life in the group home, with outside interest and occupation provided by the day centre, and perhaps with visits to and from kin."

This provides a perspective of life outside hospital albeit with the facilities that would have been found within, now dispersed throughout a wider geographical area and some wards replaced by group homes. Indeed, Jack (1998:28) describes the possibility of "institutionalisation" taking place in the "community" itself, and not just among psychiatric patients. For example, he cites the work of feminist writers in exploring the possible effects on housewives of living within the institution of the family. With regard to ex-mental health patients, who become separated from the system, they may become isolated within broader society rather than integrated within it. Such instances of loss of contact are sometimes publicised after a particular crisis that may result in public enquiries or even legal action. These scenarios are often linked to issues of "unacceptable" risk created by the perceived failure of mental health services to "keep track" of particular patients. The issue of risk as a concept in mental health will be discussed in depth in Chapter Six.

Evidence arising from early efforts at re-integrating mental patients and the problems experienced, (Ramon, 1992) is therefore worthy of further exploration. This evidence will be especially valuable if it includes sometimes-untapped sources, namely those directly involved.

(10) Conclusion.

The literature indicates that simple notions of division between the core concepts of "hospital" and "community" within much of the policy literature are inadequate. The pointers are that there were a multiplicity of divisions both within and outside

hospitals, for example, inter-professional boundaries between doctors and nurses. There was also social class division in the degree of vulnerability to coercion between patients. This was linked to the early admission of private patients into county mental hospitals.

In addition, the way that these communities have been portrayed appears too stark. For example, within the literature discussing changes, terms such as: "Mental Hospitals v Community Care" (King, 1991:15), appear to indicate these as being opposing concepts. The tendency to pose hospital and community as opposites, each with their alternate strengths and weaknesses is acknowledged by others (Butler, 1993), as is the practice of attacking or defending the separate approaches. Butler (1993:42) acknowledges the way that this "parodies" and is distant from the "real world of patient needs and care".

This chapter indicates that the very concept of community is contested, although the usage of the term frequently takes on a taken-for-granted status. The review of extant literature covered in this chapter should sensitise us to three hitherto less than fully explored aspects of mental health communities. The first is the extent to which and the ways in which community may be a product of space. Mental hospital in-patients were geographically confined in at least two senses. On the one hand the asylums were built on the edge of urban communities and represented a physical separation from the centre of new industrial processes that the mentally ill were deemed to disrupt, a physical separation in some cases now reduced by the urban expansion of the twentieth century. On the other hand, the institutions were enclosed by walls and within those walls still further enclosed by locked wards and rooms.

The containment of what were considered potentially "dangerous individuals" was one justification for confinement in what would now be termed "risk management". However, many of those historically confined could not be considered to constitute a risk to themselves or others.

The second aspect we should be sensitised to is the manner in which engagement in common occupation creates an occupational community, as in the case of fishing or coal-mining communities. Occupation for the mental health patient could be a matter of workshop, horticultural, agricultural or domestic activity, with these activities rationalised as having therapeutic qualities. These activities might also be linked to the hierarchical nature of such communities with access to types of work used as part of the system of rewards and punishments. Finally, institutionalising practices may continue even after the demise of the large institutions with their fixed geographical position and local occupational focus.

The third element of community to be attuned to is that of the community constituted through choice and a sense of belonging. We need to consider such notions critically, not only because, as we shall see, for some patients the belonging was not a matter of choice if they were detained under mental health legislation in a compulsory manner, but because a sense of belonging may be partial, ambivalent or may change over time and circumstance.

For all these reasons, the concept of community is far more complex than the work of either Gittins or Butler allows. Rather than start from a taken-for-granted conception of what community is, and contrast the presumed experiences within

mental health hospitals with such mythical ideals, what is required is to analyse how communities were actualised on the ground, to analyse actual hospital communities such as St Crispin's, for what they might tell us about the complex and contested concept that is community.

In conclusion, this short review has helped to orientate the research process towards some major theoretical influences during exploration of data in the pilot study and subsequently in the following of research pathways as they have emerged in the main study.

Chapter Three will describe the research methodology employed and discuss the development of the approach as an appropriate tool to explore issues relating to conceptualisations of community. The chapter will begin with a description of the pilot study carried out at the beginning of the research process.

CHAPTER THREE

RESEARCH METHODOLOGY

Introduction.

The nature of "community" has been defined in many different ways. Services for those deemed mentally ill are now based around policies of "care in the community". This implies that the organisation of the provision of care that preceded the current approach was not carried out within, but rather outside the "community". Since this care was largely within hospitals, the un-stated implication is that hospital and community are to be regarded as opposites.

Previous research by this author, in 1997, considered the nature of community as it was reportedly perceived from within large mental hospitals in a time before community care policies became the norm. Six interviews had originally been conducted during this earlier research, for work towards a degree of Master of Arts.

The subject for the degree of Master of Arts was an historical work-study of hospital psychiatric nurses based between 1940 to 1965. During the course of this earlier research, a prominent recurring theme related to the nature of the communities within which the nurses operated. This area of interest, although briefly discussed within the original results, presented itself as being worthy of a deeper exploration and led to the current project. It was evident that some of the beliefs concerning the supposed opposition between the concepts of hospital and community were not reflected in those data. It is important that conflicting issues are explored and some

of the pathways leading to today's approach to care are understood in a proper context.

As the theme relating to the nature of the community (associated in particular with St Crispin Hospital in Northampton) originally presented in the earlier research, it was considered important to re-visit that work for a more focussed exploration. This project therefore began with a re-examination of the data used in that earlier work and focused on material relating to the nature of the communities within three hospitals represented.

The methodology developed during this earlier work was based around oral history combined with other sources. The experience gained in using this approach informed the development of a methodology for this project, involving the use of oral history with other sources and a modified Grounded Theory approach (Glaser and Strauss, 1967). This will be discussed in detail within this chapter.

In the pilot stage for this research project, the six interviews used in the earlier research were re-analysed, and together with one new interview and other sources, were used to generate themes for an exploration of theoretical concepts of community in mental health between 1935 and 1965. This period presented as a watershed at St Crispin Hospital in respect of management, environment and treatment practices and was therefore chosen for a focussed exploration. Other details relating to the division of data are presented in more detail later in this chapter.

The development of the research, as noted, led to the formulating of a suitable methodology to explore these questions raised in the original data, and this process will be described next.

The pilot stage and the main research study will next be presented in the following order:

The research methodology of the pilot study.

(1) Introduction.

(2) Methodology.

(3) The re-working of six oral history interviews.

(4) A brief outline of the main methodological conclusions arising from the pilot study.

(5) The results of the pilot study.

(6) Conclusion.

The research methodology of the main study.

(1) Introduction.

(2) The quality of data.

(3) Validity.

(4) Data collection.

(5) Interviewees and ethical issues.

(6) Sample selection.

(7) Interviewing.

(8) Interview schedules.

(9) Access to other sources.

(10) Analysing the interview data.

(11) The sequential analysis of the interview data.

(12) Documentary archive material.

(13) Photographs and film.

(14) Conclusion.

The pilot study

(1) Introduction.

The pilot study was largely inductive and exploratory in nature, concentrating on the emergence of issues within the re-analysis of the extant oral history data. The methodology was chosen as one that would enable the use of use a flexible approach. The adoption of computer-based techniques suitable to deal with large quantities of mainly interview, but also other sources of data, proved necessary. The development of a methodology for the pilot study performed two roles. First it tested the viability (and potential usefulness) of further research on theories of community in mental health. Second, it informed the approach for a main study. Details of the pilot study and lessons that were learned will be outlined next.

(2) Methodology.

A literature review that explored a potentially appropriate research methodology was conducted. It indicated that within an overall historical strategy, the use of a research approach that is interpretative and grounded mainly in the lived experiences of individuals would be most appropriate. A process containing modified aspects of a

Grounded Theory approach (Glaser and Strauss, 1967), and based on multi-method data collection, was identified as effective in re-analysing oral history data along with other sources. The methods of research of the historian were also drawn upon (Jenkins, 1991; Tosh, 1984). For example, in relation to the historian's model, Yow (1994:224) comments:

> "If the researcher is using a collection of life histories, usually gathered around a theme such as a particular occupation or movement, then it is the common meanings of the shared experience that are sought."

Further methods and strategies will be outlined following the presentation of results of the pilot study.

(3) The re-working of six oral history interviews.

The approach consisted of the re-working of the small sample of transcripts of six oral history interviews used in the earlier research. They were conducted with six retired nurses from three mental hospitals. Three nurses had worked at The Towers and Carlton Hayes in Leicester and three at St Crispin in Northampton. As noted, they were originally conducted for a small-scale historical work-study by the author of mental nursing from 1940 to 1965. The interviews were conducted using oral history interview guidelines and were recorded on audiotape. They were originally transcribed using "VoicePad Pro". Later, the files were converted into Microsoft Word for Windows 97. Each interview was transcribed in full. Other relevant impressions, such as of the use of gestures and other body language by the interviewee, were recalled and recorded afterwards in research notebooks. As suggested by Glaser and Strauss (1967), these notes were used as part of the analytical process. At the time that consent was obtained for the earlier study, all

interviewees had consented to the original material being used, by this author only, for any other personal uses, including for further research.

The re-working of this material concentrated on re-examining concepts in relation to "community" that emerged from the original exploration of these data. It also focussed on previously unused material in the original transcripts. Re-analysis of the original oral history interviews generated new theorising concepts and core propositions. The re-analysis of the transcripts was contemporaneous with the literature review as well as the accessing of other sources. The original six oral histories that were subject to re-analysis revealed insights into how "community" both within and outside mental hospitals was conceptualised by the respondents.

In addition to the re-analysis of six interviews, one new interview was undertaken as part of the pilot stage. This new interview focused specifically on the nature of hospital communities, and tested propositions that had arisen from the data originally obtained using a broader field in exploring the working lives of mental nurses. This pilot stage identified emergent themes that could be explored using theoretical sampling (Strauss, 1987).

(4) A brief outline of the main methodological conclusions arising from the pilot study.

The adaptation of grounded theory used in the pilot study worked efficiently within a limited multi-source analysis but it was recognised that the addition of a wider, complementary, approach in an overall strategy was desirable in the main study to follow. Layder (1993:108-109) recommends a multi-strategy approach that is not

"'...anything goes' but is 'open' to as many strategies and analytic cuts of the data as possible." Layder also discusses the importance of retaining an overall view of micro and macro elements during research. He describes the multi-strategy approach as being disciplined but flexible.

Denscombe (1998:83), in discussing multi-methods, advises choice based on suitability for a particular need. He describes how questionnaires, interviews, observation and documents may "be seen as competing" but can also be judged as complementary. The decision should be based on appropriateness. The pilot study indicated that the sources of data accessed in the main study that would provide most advantages should be reflective of a flexible, multi-method approach.

In this project, questions of reliability, validity and representativeness have been considered alongside recognition that data from any source has its limitations as well as strengths. For example, in attempting to understand historical notions of "community" in mental health, it has been important to remember that the services were strongly hierarchical with influential power relationships between groups and particularly between staff and patients. Most archive material derived from the mental health services (apart from clinical notes written by nurses that were inaccessible to the researcher) has been written either by or about the most powerful individuals, that is senior staff such as consultants or administrators. Other work on the history of the services has been written by academics, some with a background in mental health. Foss and Trick (1989), in constructing a history of St Andrew's Hospital in Northampton, focus primarily on the powerful individuals who were influential in the institution's development. Parallel accounts from the less influential

and powerful are lacking. This factor generally has influenced how the histories of mental health services have been viewed, and can skew perceptions. As noted by Jenkins, (1991:17):

> "The fact that history *per se* is an ideological construct means that it is constantly being re-worked and re-ordered by all those who are variously affected by power relationships; because the dominated as well as the dominant also have their versions of the past to legitimate their practices, versions which have to be excluded as improper from any place on the agenda of the dominant discourse."

The intention, in this research project, has been to widen the scope of the study beyond a study of powerful individuals. For example, rather than simply recording the influence of powerful individuals, the intention has been to explore how that dominance arose and the effect it has had on theoretical interpretations of the nature of mental health communities. In order to do that effectively, the pilot study drew attention to the fact that this would best be done in a focused way, concentrating in particular on one location, St Crispin Hospital in Duston, Northampton, within which the author, as noted in the Introduction, worked during the 1970s. Although material applying to other institutions and from other sources has also been utilised, it was recognised that this has implications for reliability. However, the study does provide an understanding of the evolution of mental health communities of one time and at one place, and to this extent may be regarded as internally valid.

(5) Results of the pilot study.

The analysis of data within the pilot study revealed a number of new themes. Some of the material emerging within the data was also reflective of concepts recorded in existing literature. However, the extant literature is itself a reflection of the selection and differential survival, since there are only limited accounts of ordinary members of the patient, staff and associated populations.

Original contributions to knowledge that were anticipated potentially to emerge in a full study included the following:

(1) A re-appraisal of the role of voluntary bodies.

(2) Hospital and community – were they "opposites"?

(3) The sense of mental health patients "belonging" and "having a place" in the community.

(4) A reappraisal of the effects of the introduction of phenothiazine medication.

(5) The recruitment of nursing staff from "outside communities".

(6) The influence of staff recruited overseas in the initiation of change.

(6) Conclusion.

The pilot study provided the opportunity to test methods to achieve the successful reduction of data from the original six oral history interviews in a way that drew attention to concepts of community and identified themes that could guide further research. It also showed that themes that arose in the early stages of the research had the potential to successfully contribute new knowledge. This originated from the analysis of a small sample of re-worked data associated with other sources. The research design proved effective in exploring historic themes and concepts of community in mental health in what was a small and limited sample. The work also informed proposals for the main study. Several themes emerged, such as the role of volunteers in mental health communities, which guided subsequent interviews. A main theme that was already forming at this early stage was a re-appraisal of the assumption that hospital and community were opposites. The methodology of the main study will be described next.

The main study

(1) Introduction.

The aim of developing the theory of community in respect of mental health, during a specific period between 1935 and 1965 has led, in this research project, to the development of a multi-method research tool. This has been necessary where there is difficulty in being specific about a concept (i.e. "community") that is nebulous and capable of many interpretations. However, it has been argued that a potential "remedy lies in analysis and discrimination." (Minar and Greer 1969: ix). This has been an aim in developing a methodology for this study.

The choice of a modified grounded theory approach as part of a multi-strategy methodology was chosen for the main study based on the experience gained from the pilot study. The aim of the research has been to obtain new knowledge from a number of sources and to generate new insights. The sources used include the following:

(1) Extant literature.

(2) Oral History interviews.

(3) Written archived material and other records.

(4) Photographic material.

(5) Film and video material.

Information gleaned during the pilot study was further explored and tested using a more detailed and rigorous approach. In doing this, it has been intended to take a detailed look at those involved in past mental health services. It examines the

respondents' opinions of the nature of the social structures in which they lived within the institutions. This approach, in using a number of complementary sources, has been intended to add strength to the results through the opportunities for triangulation presented by this route:

> "Triangulation provides social researchers with a means for assessing the quality of data by coming at the same thing from a different angle. It allows them to gauge the validity of the data in relation to alternative positions." (Denscombe, 2002:104)

This is particularly advantageous when an inductive method, such as a grounded theory type approach, is being pursued in an area where there is relatively little previous work, or to gain a new perspective on that work. Gilbert (1993:23) comments that induction "...is the basic technique for moving from a set of observations to a theory and is at the heart of sociological theory construction...". It enables the research to identify emerging information and link it in a cohesive way. May (1993:22) describes an inductive approach as;

> "...based on the belief, as with empiricism, that we can proceed from a collection of facts concerning social life and then make links between these to arrive at our theories."

May (1993:23) sounds a note of caution in respect of what originally guides researchers to collect data. They may have been influenced by funding or have a particular interest in an area of research. They may have access to resources to test ideas.

> "As a result, researchers should make their theories or hypothesis explicit and not hide behind the notion that facts can speak for themselves. This is not a situation from which researchers can escape for their interpretations are an inevitable part of the research process. An alternative to induction is to make the theories or hypotheses which guide our research explicit."

The use of a mixed methodology has advantages in that a number of approaches, including quantitative methods may be used, when appropriate, to expand and better understand what emerges from qualitative data. Layder (1993:113) talks of counting approaches as a rough check in "a battery of checks" by some researchers to reinforce qualitative pattern discoveries. This study, although using primarily face to face interviews, takes advantage of the flexibility offered by a mixed approach.

(2) Quality of data.

The issue of quality focuses around two broad questions (Denscombe, 2002:98). The first is whether the data is valid and the second whether the method is reliable. In this project, owing to the nature of those data used, the issue of reliability is not based on the replicability demonstrated by a measuring instrument (such as a questionnaire) or by a repeatable experiment. It is based on the data generated by a number of methods but in particular, semi-structured interviews with individuals, who in the past were associated with mental health services. The individuals whose memories have been accessed come from a variety of backgrounds and were mainly retired hospital staff and ex-patients. The interview data has been derived from respondents from different geographical areas, although most retired hospital staff were associated with St Crispin Hospital.

The reliability and external validity of the research turns partly on the processes for the recruitment of interviewees. In this research, recruitment initially depended to a large degree on networking and goodwill. The consequence was that recruitment was affected by problems of access and situations where individuals declined to be interviewed. Specific difficulties related to the recruitment of ex-patients in the

Northampton area. Two ex-patients from Northampton, who comprised the sole response for potential interviewees, even after an appeal through the local press, eventually declined to be interviewed after initial meetings. In order to avoid silencing the experiences of ex-mental health patients, that is, the views of the less powerful, interview material from the National Sound Archive was used to provide a patient's "voice". These difficulties and the attempts to remedy them will be discussed in depth later in this chapter.

Parahoo (1997:236) notes that "convenience samples are probably the most frequently used of all types of sample in both types of research". In nursing research in particular, in a review of 720 articles by Moody et al (1988), Parahoo notes that this was the case in 74 per cent. Certainly, in the case of the sample taken from St Crispin Hospital, there was a strong representation of ex-staff providing a culture-specific view of that institution. There was also, however, representation from Leicester hospitals in the shape of three retired nurses whose interviews were part of six re-analysed from the earlier study. Although events will not be directly linked, there occurred from time to time a commonality of experience of life within an institution. Respondents have spoken of similar issues from different perspectives and in this respect, they are equally valid individually. In addition, any two researchers will be subtly different in using qualitative methodology. Later, in the process of the following of particular research trails, further individuals with connections to mental health communities were also recruited for interview. The resulting sample may have the superficial appearance of a "convenience sample" but each interview was used to further pursue a particular insight. This resulted in both a variety of staffing types and a variety of nursing grades being recruited with others,

who between them reflected a wealth of experience over many years in mental health communities.

This research also drew upon documentary records. Tosh (1984:63) comments that such records are mostly studied from one of two positions. First how did the institution that produced the records evolve, and second, what was its function "in the body politic".

> "In this context reliability is hardly the issue, for the records are studied not as *reports* (i.e. testimonies of events 'out there'), but as parts of a *process* (be it administrative, judicial or policy-making) which is itself the subject of enquiry. They are as much the creation of an institution as an individual, and therefore need to be examined in the context of that institution – its vested interests, its administrative routine, and its record-keeping procedures..."

This research project has been an historical exploration of the past nature of mental hospitals in developing the formulation of theories of community. In this respect, issues surrounding reliability are important but the fact that the research has focused on one institution in particular must be taken into account when generalisabilty is being considered. The experiences of those associated with other hospitals may have differed in fundamental ways. However, his does not mean that results concerning theories of community are automatically lacking in external validity. As stated by Tosh above, it is "the process" of matters that is being finally studied. The way in which such data has been obtained has been very important in the construction of a theoretical framework. Denscombe (1998:216) talks of "a trail of discovery" in which each:

> "...new phase of the investigation reflects what has been discovered so far, with new angles of investigation and new avenues of enquiry to be explored."

The selection of individuals for interview in the main study reflected and was determined by lines of exploration. For example, a retired gardener who had previously worked on St Crispin Hospital farm, at the time it was managed by an earlier interviewee's father, was sought to further explore insights given by her into its activities. These included the patterns of work carried out by patients and others during the time that he was working there as a "dairy boy".

(3) Internal Validity.

Internal validity has been recognised as of particular importance with research material. Silverman (1993:156) discusses claims to validity in field research and the criteria by which it is judged. He describes often-used strategies as:

1) Understanding of the "Hawthorne effect" with an estimation of the influence of the presence of the researcher on the area of research.
2) The values of the researcher and the influence this may have on the process.
3) The involvement of the interviewees in checking the results of the research. This is described as "the truth status of a respondents account" and is known as "respondent validation"; i.e. do they "recognise themselves".

Silverman believes that these methods "are usually inappropriate to qualitative research" and states that in "the case of interview and textual studies, reliability can be improved by comparing the analyses of the same data by several researchers" (Silverman, 1993:166). As an alternative, the following is offered:

(1) Methods of generalising to a larger population.

(2) Methods by which hypotheses may be tested.

(3) The use of simple procedures of counting.

The recommendations by Silverman were implemented first by the use of previous research in comparing results obtained from this study with the results from earlier existing work. One example of this was in exploring a description of life within Severalls Hospital in a history written by Gittins (1998). Earlier extant studies written on the history of mental health services including, for example, that of Scull (1979), Jones (1972) and Nolan (1993) were also accessed. With respect to St Crispin Hospital, staff accounts of life within and around that institution were examined with regard to re-analysed material from three narrators from the earlier study, who had experience of working in other areas. As already noted, three interviewees had worked in hospitals in Leicester. Two had worked at The Towers and one at Carlton Hayes who had, earlier in her career, also worked at St Bernard's Hospital in Middlesex. Emerging ideas could also be tested by discussing particular concepts with individuals who had experience working in areas that had been the subject of contributions from earlier interviewees. An example of this approach was in investigating the role of particular, seemingly influential individuals, in the implementing of post-war reform at St Crispin Hospital. The perception of the importance of such individuals had been hypothesised by three retired St Crispin Hospital nurses in re-analysed interviews from the earlier research study and by an interview with a former head gardener's daughter conducted for the pilot study. This concept was tested by focused, but not leading, questions in later interviews. Simple counting procedures have been utilised in the research where possible. For example, the number of Northampton interviewees who mentioned the influence of a post-war Medical Superintendent, who arrived during the crisis period, as important in developing reforms at St Crispin Hospital, was three out of seven. However, the three were numbered among just five retired clinical staff interviewed from that area.

In considering oral history specifically, Yow (1994:221) describes a method to evaluate the quality of interviews. This includes recommendations to

> "...try to corroborate the information on the tape with other documents, written and oral. Listen closely to the testimony to determine if there is consistency within the testimony".

In addition, Yow (1994:221) suggests:

> "...look at the narrator's credentials for the testimony on specific issues: Does he (sic) know what he is talking about? Is this firsthand information? How close was he (sic) to the events recounted? How does the purpose of the narrator affect the testimony? How are the reflections on the past influenced by the present situation? Are events or feelings remembered in such a way that they show the influence of present feelings – such as a feeling of abundance and well-being so that harder times in the past are minimized in the telling?"

The guidelines provided by Yow have been followed in this research project. For example, because the respondents' narratives have been in the style of life histories, it has been possible to develop an understanding of the career history of individuals and some knowledge of their credentials for discussing issues raised. In addition, some narrators have cross-referenced others also interviewed during their contributions. An example of this is that two retired nurse interviewees from the re-analysed earlier study, and two, a nurse and a doctor in the main study, mentioned the reforming role of another nurse interviewee. Their contributions supported each other in respect of this information. After interview, notes were made in research notebooks in respect of any seemingly significant reactions from respondents during the course of interviews. An example is the noting of the reaction of a former nurse who appeared to still remember with some emotion an attack that had been made upon him by a patient who had attempted to take his keys.

The issue of internal validity has been important in respect of not only the research process but with respect to the ethics of the study. The use of data drawn in

particular from sometimes elderly and vulnerable individuals can create the danger of misrepresentation as well as inaccuracy if it is not properly handled from the beginning.

In a check of internal validity of the primary interview data used in this study, interviewees received transcripts and taped copies of their interviews and were not contacted for a further two weeks while they examined them. If they required extra time, there would have been negotiation on this point, although none did. The opportunity to make corrections or amendments was also offered. One interviewee took advantage of this, providing a separate written paper outlining extra information. The significance of this was interpreted as a wish to clarify points concerning doubt about particular recalled information. It did not fundamentally change aspects of the testimony. Another added extra information in the margins. As the additions did not refute any of the interview material, there were no methodological implications in accepting the extra detail. The significance was attributed to extra detail being recalled after the interview had taken place. The overall intention was to ensure that the interviewees were happy with what they expressed in the interview situation as representing their view. This helped to make it possible that theory generated from the study has "grab" to the respondents (Glaser and Strauss, 1967). There were no requests for the respondents to delete any of the material given at interview. Yow (1994:202) comments that "You could offer the alternative of deleting the part of the copy but not in the original that the narrator keeps. But if he or she insists on deletion, you must delete." Details of the process used in selecting sources will be explained next when the method of collecting data is explained.

(4) Data Collection.

The design of this study is that of a multifaceted approach in the sampling of data. Layder (1993:112) outlines methods of data collection in field research and of these the following two have been used:

(1) Historical documents.

(2) Semi-structured interviews.

In addition, as already noted, other sources have also been utilised. Jolly (1997:85) describes the need to be flexible and open-minded in the variable nature of the research process.

(5) Interviewees and ethical issues.

In order to begin to access local ex-patients, permissions sought to conduct the study included an application to the University Human Research Ethics Committee; an application to the Northamptonshire Local Research/Ethics Committee; and an appearance by the researcher in person before the Northamptonshire Local Research/Ethics Committee.

In order to meet the requirements of the ethics committees, the following documents were submitted for approval (Appendix One: Ethical Committee Documents). These included:

- An application form outlining the research aims objectives and methodology.
- An explanatory letter, information sheet and consent form for the proposed interviewee.
- An explanatory letter and consent form for the proposed interviewee's General Practitioner.

- An explanatory letter and consent form for the proposed interviewee's Consultant (if one was involved).
- A joint consent form for the potential interviewee and any closely involved other such as a carer or a professional such as a Community Psychiatric Nurse.
- A consent form for the respondent.
- A research protocol.
- A copy of the ethical guidelines of the Oral History Society of which the researcher is a member.
- A copy of the curriculum vitae of the researcher.
- A copy of the curriculum vitae of the first supervisor of the researcher.

Following an appearance by the researcher at a meeting of the committee, the committee confirmed permission for the procedures requested by the researcher. Following an initial approach to General Practitioners, they would be informed if their patients were to be included in the study. In addition, it was confirmed that any study participant would approve a transcript of the tape recording before any information was taken from it. On this basis, the Local Research Ethics Committee gave approval. No one receiving treatment for an active mental health problem at the time of the research was knowingly approached.

(6) Sample selection.

The selection of a sample for interview was recognised as important. In order to derive a balanced understanding of the results, it was necessary to obtain a broad spectrum of input. Moreover, flexibility in the research process in following pathways of exploration, as part of theoretical sampling, made it necessary to seek

interviewees to pursue to saturation particular lines of enquiry. An example related to the interaction between the patients and staff of St Crispin Hospital in Northampton and the residents of the village associated with the hospital. This issue was raised first by an ex-nurse in the earlier research project who had lived all his life within the local community. The subject was further explored with two other individuals who had also lived their lives within the same community, a retired hospital gardener and a nurse. It was also discussed with a doctor who spent most of his career at St Crispin Hospital and lived nearby. In addition, the question of relationships between mental hospitals and communities local to them was explored with a respondent, the daughter of a publican, who had spent her childhood within the Liverpool area of Rainhill Hospital.

There are obvious historical, demographic, ethnic and cultural differences between the populations of Liverpool and Northampton. Principally, Liverpool is much larger and unlike Northampton, which is landlocked, a port. This has contributed to the ethnic and cultural mix of a population that has historically had a greater diversity than Northampton. This is particularly so in relation to descendants of visiting sailors and numbers of Irish immigrants who arrived following the potato famine in the mid-nineteenth century. In exploring issues of reliability in comparing hospitals based in such widely differing areas, it is important to consider these differences.

Conversely, it is equally important to explore if there were similarities within the cultures of mental hospitals and their associated populations. This is in the sense that they constituted occupational communities that were structured in a similar geographic sense and operated in a similar way. The same, it is argued, applies to

interviewees from other hospital and associated population backgrounds, not associated with St Crispin Hospital in Northampton.

In addition, archive material was sought that revealed attempts to develop education, eradicate stigma about mental illness and develop closer relationships with the community during the early 1960s. Existing literature on the development of early moves to community care was also scrutinised, for example, King, (1991:64) and Barham (1992). This work constituted an exploration of the "separateness" or otherwise of the two groups.

Semi-structured interviews, dedicated to the exploration of concepts of community in mental health, were used for the generation of data incorporated within the sampling of twelve former staff, volunteers and significant others. Six of these were primary data re-analysed from an earlier study and six were new in-depth interviews subjected to primary analysis. Eight interview transcripts with former patients were obtained from the National Sound Archive at the British Library and subjected to secondary analysis. The rationale behind obtaining these eight former patient interview transcripts will be described later in this chapter.

Interviewees for the main study originated from a number of groups who contributed to mental health services and were sought first by means of networking. A detailed description of the contributors and the nature of the analysis of their testimony will be presented later in this chapter (also, see Table One: page 117). Three of the interviewees from an earlier research project completed in 1997 were known to the author prior to the research project. Three were not. In the main study for this

project, three out of six interviewees were known to the author. The methodological implications in respect of this are that like-minded individuals may have been sought. However, although known socially, the author had not worked directly with any of the interviewees. In addition, the author had spent only approximately seven years working in St Crispin Hospital over two periods starting in 1970, outside the period of the study, whereas the respondents known to him had each spent many years, including during much earlier periods of the 1950s and 1960s. It would not have been possible to accurately anticipate their views on that basis. As research trails were followed, extra possible respondents were contacted based on comments or information from earlier interviewees.

A major difficulty was experienced in obtaining ex-patients from Northamptonshire who had been hospitalised between 1935 and 1965. An enquiry about advertising for ex-patients, in a large circulation local newspaper, led to an offer for a mention in "Features" in June 2002 by a journalist working for the newspaper. This was not successful in obtaining a response. Other, concurrent, attempts to obtain respondents, who had been patients in St Crispin Hospital between approximately 1935 and 1965, were equally unsuccessful and will be described in more detail next.

The failure to obtain any primary interviews with ex-patients in the area of St Crispin Hospital inevitably weakened the research. Having been in hospital, many of this group continue to receive care and treatment outside, sometimes still under supervised conditions. Moreover, two patients identified eventually declined to be interviewed. The first was contacted and then recommended by a retired member of the medical staff who had stayed in touch with her. A second, presented via MIND

in Wellingborough, and agreed to being visited to receive further details. The first individual was visited at home at her own request but declined to be interviewed explaining that although she found the subject interesting, she had agreed to the visit primarily out of respect for the doctor who had recommended her (Research Notebooks: 26/7/02). The second interviewee, who had expressed enthusiasm when first approached, was seen at MIND as he wished and wanted to do an interview straight away. He subsequently seemed overwhelmed by the amount of literature related to obtaining informed consent presented to him, as a requirement of an ethical approach, about the nature of the research and its aims and objectives prior to a second meeting. He became anxious, as did his sister, that it may cause a return "to previous troubles" and telephoned to withdraw from the project. He was reassured and with his verbal permission, a member of staff at MIND was informed that he had withdrawn, and the circumstances. The reason that permission to inform a MIND worker was sought was to ensure that support was available via an appropriate person if there was any lingering anxiety (Research Notebooks: 30/12/03). It is instructive to note that, partially as a consequence of supposedly ethical procedures put into place to protect respondents, the voices of some of the most oppressed people in society have effectively been silenced, with the possible unintended consequence that service provision they perceive as detrimental may have escaped the scrutiny of research. Reluctance to testify may have been the result of other reasons in addition to the above.

Included in these may have been the following:

- The fear of the loss of anonymity combined with a reaction to memories of the perceived stigma of mental illness.

- There may be no obvious concern to them that their story is silenced by not participating and may just wish to forget the events of the past.
- Distrust of the research process or the researcher.
- Finally, there is the fact that others may not wish to take part for no specific reason other than it might be seen as a trouble and a nuisance.

The search for local ex-patient volunteers was problematic for another reason. The avoidance of general intrusion was always an inhibiting factor. This applied in particular with individuals who were currently receiving treatment and deemed to have a still active mental illness. A decision relating to an ethical approach in this research project was to not interview such individuals currently receiving treatment for active conditions. This undoubtedly narrowed down the number of suitable interview possibilities. Undoubtedly one problem in recruiting was the enduring nature of some mental illnesses. Attempts to find suitable ex-patients who might be interested included, as well as general networking, contact with individuals and organisations. These included:

> Local statutory services, including; Nurses (community and in-patient managers); Consultants for the elderly mentally ill; Age Concern; MIND (Wellingborough, Kettering, Corby, Oundle, Thrapston/Raunds and Rushden branches in Northamptonshire); Workbridge; Local care homes with ex-mental health residents; other individuals involved in mental health and the local press (Research Notebooks: 2002).

Furthermore, two individuals with a long-stay hospital background, initially known to the author professionally during rehabilitation in a group home, and who have

remained as friends were not approached for ethical reasons. It was felt that unfair pressure would be placed on them by a request to contribute and make a truly independent decision difficult. It was also viewed as being possibly exploitative of the friendship.

The fact that the population of ex-patients, and in particular those who spent time in institutions within the main period of the research study, between 1935 and 1965, are in the advanced years of their lives is important. With age also, often come feelings of vulnerability. Many have died or are ill and frail, and selective survival is another social process that contributes to the silencing of accounts of people who had experience of mental hospitals in the time period covered by the research.

Although there were possibly many similarities of experience for both patients and staff throughout the service, a failure to obtain any local individuals would still undoubtedly have had an adverse effect on validity. Themes developed from testimony providing only an ex-staff perspective may not have carried meanings recognisable to patients from the same environment. In addition, ex-patients who came from a variety of hospital backgrounds may have had experiences that differed markedly from institution to institution. As noted earlier, however, they may also have had some similar experiences based on the unique nature of the geographic-occupational communities of which they were part.

Because of the importance of a patients "voice" being present in the research process, eight interviews with ex-patients from psychiatric hospitals who were admitted between 1935 and 1968 were obtained from The Mental Health Testimony

Project, part of the Millennium Memory Bank at The British Library and subjected to secondary analysis. Obtaining an appropriate sample of transcripts of interviews with ex-patients, who had been hospitalised between approximately 1935 and 1965, from the archive required considerable sifting due to the disparate nature of the interview tapes and transcripts stored there. The period of admission in the selection was extended to 1968 to provide some flexibility. Eight interviews were chosen following the study, on-line, of summary accounts of patients' testimonies. This process will be described in detail next.

In June 2002 when access was first made, in the classification "C905 and mental health", there were 103 life histories funded by the Department of Health that constituted the "Mental Health Testimony 1999–2000 Archive". These interviews had been fully transcribed by researchers for the National Sound Archive and could be sent as email attachments subject to agreement by the archivists and with a supporting letter from the research supervisors. Initially, all mental health testimony summaries were screened to identify any from the Northamptonshire area. This search was unsuccessful. Subsequently, all of the 103 summary accounts were downloaded and studied. One summary that was downloaded was wrongly filed and not in fact part of the mental health project (Research Notebooks: 29/6/02).

A final eight full interview transcripts, sent by the sound archive as email attachments, were chosen for analysis based on the following criteria:

- The individuals had been present as patients in mental hospitals within the time zone of the study.
- Four were female and four were male, providing a gender balance.

- To achieve some representation of social and ethnic diversity.

The final range of all interview material subjected to analytical breakdown was as follows:

(1) Six interviews conducted by the researcher in an earlier work-study as primary data. This material was re-analysed for the current research in exploring for evidence of the nature of community in mental health services between 1935 and 1965. The interviewees were retired mental health nurses, three male and three female, and the years of their work experience crossed the period being explored in the current project. All six had spent almost all their working lives in mental health services. The individuals interviewed for the earlier research whose transcripts were re-analysed, were as follows:

"A" A retired female nurse who started working in Carlton Hayes Hospital in Leicester in 1957 after previous experience in London.

"B" A retired male nurse who worked for over thirty years at St Crispin Hospital after a local childhood. He began his career at the hospital in 1939.

"C" A retired male nurse who relocated at six months of age to Duston in Northampton when his father obtained work as a nurse at St Crispin Hospital. He began work at the hospital, initially in another role at the age of 14 in 1934.

"D" A retired female nurse who began work as a cadet attached to Carlton Hayes in 1954 and later, after qualifying, worked at The Towers Hospital in Leicester.

"E" A retired female nurse who began work at The Towers Hospital in 1962. She had been born on Antigua and educated on Monserrat, moving to Britain in 1962.

"F" A male nurse who moved from his home in Austria in May 1954. He spent his career at two Northampton hospitals, but trained at St Crispin.

(2) Six new interviews that were subjected to primary analysis with the following individuals:

"G" A former Head Gardener at St Crispin Hospital, now retired. This individual spent his entire working life at St Crispin Hospital and always lived locally.

"H" A retired Nurse who began his career as a student at St Crispin Hospital and worked his way up to Nursing Officer grade, leaving before the institution closed.

"I" The daughter of the former Farm Manager at St Crispin Hospital who spent her childhood there and interacted a lot with those who either worked there, or were patients in the institution.

"J" A former Deputy Medical Superintendent and later Medical Director of St Crispin Hospital who witnessed most of the changes taking place there for a period of approximately thirty years.

"K" The daughter of the licensee of a public house close to Rainhill Hospital who had contact with patients who either worked in, or visited, the premises her father managed.

"L" A founding member of the St Crispin Hospital volunteers who worked within the institution during the formative years of the "opening up" of the hospital to outside influences.

Among the respondents who were interviewed, one, an ex-nurse, worked for nearly forty years within the same institution. The retired head gardener, who also spent his entire working life within St Crispin Hospital, worked daily with patients. Six of the Northampton interviewees had "lived-in" or within the village local to St Crispin Hospital where they worked. Three of the original interviewees, who were nurses, lived and worked in Leicester. They had also lived either within a hospital or within the area local to it. Networking was the most effective means of recruitment among this group largely because most of them knew each other and although they were not necessarily in regular contact, were aware who might be interested.

(3) Eight video interview transcripts, available for research, were accessed from the National Sound Archive of the British Library and subjected to secondary analysis as part of this research project. They were originally conducted as part of "The Millennium Memory Bank" to record the experiences of ex-mental health patients. None of the ex-patients was from the Northampton area. These interviews would also have offered advantages in terms of generalisabilty in conjunction with local ex-patients had they been obtainable. The interview transcripts used are from the following:

"M" A man who was first admitted to Napsbury Hospital in 1965. He was born in the former Soviet Union.

"N" A woman first admitted as a voluntary patient to Holloway Sanitorium, Virginia Water in approximately 1951.

"O" A man who had experience of residence in Horton Hospital where he was first admitted in 1934.

"P" This woman was first referred to Belgrave Children's Hospital where she saw a Child Psychiatrist. From there, she went to the Adolescent Unit Bethlem Royal and was also in other institutions including Rampton, The Henderson and Cane Hill Hospitals.

"Q" This man was admitted to Stanley Royd Hospital as a voluntary patient where he received Electroconvulsive Therapy (ECT) and Insulin Therapy.

"R" This woman was admitted into the North Middlesex Hospital in her early twenties. She was born in 1928.

"S" This woman was born in 1943 and was first admitted to Rainhill Hospital under a Section of the Mental Health Act (1959) in 1968.

"T" This man was born in Asia in 1937 arriving in England in 1958. Becoming mentally ill in the early 1960s he was eventually first admitted to St. Bernard's Hospital where he received ECT. After spending time in prison he later, from the 1970s, spent seventeen years in Napsbury Hospital.

All of the 20 interviews, including the six of re-analysed primary data, the six new primary interviews and the eight secondary analysed interviews with ex-patients from the National Sound Archive were in-depth and constituted 365,885 words in total.

All final data sources and the status of analysis of each are displayed for quick reference in Table One next.

Table One: All final data sources and the status of analysis.

Data Type	Status of Analysis	Source	Where
6 in-depth interviews for earlier research. (1997)	Primary data. Re-analysis.	Retired nurses.	3 Leicester. 3 Northampton.
6 new in-depth interviews.	Primary data. Primary analysis.	1 Gardener. 1 Volunteer. 1 Publicans daughter. 1 Nurse (retired). 1 Doctor (retired) 1 Farm Manager's daughter.	5 Northampton. 1 Rainhill
8 in-depth interviews from the National Sound Archive.	Secondary analysis.	Ex-hospital patients.	Other national areas.
Archive material.	Secondary analysis.	Public Record Offices. and private individuals.	Northampton. Leicester.
Archive material (Photographs and video).	Secondary analysis.	Northamptonshire Film Archive and others.	Northampton & Wellingborough.
2 interviews.	Declined.	Ex-hospital patients.	Northamptonshire.
2 interviews.	Not approached.	Ex-hospital patients.	Northamptonshire.

(7) Interviewing.

In addition to the re-analysis of six oral history narrations, interviews specific to this research were used as the main source of data. They were semi-structured oral history interviews in form and were tape-recorded and transcribed by the researcher.

Some material derived from informal discussion was noted down in research notebooks with the permission of the respondents involved and usually derived from informal pre or post interview comments when the recorder was not running.

The interview process was, as noted, developed based on the experience gained during earlier research and the pilot study. The in-depth interviews used in the main study were recorded on audiocassette. This is the most common method of data collection used in oral history research. A Sony digital recorder was used as a backup and the material then downloaded onto a computer. The interview was then played back on a digital voice editor that made transcription easier and overcame some of the problems associated with constantly switching backwards and forwards on a cassette recorder when transcribing. All interviews were transcribed in full by the researcher.

For reasons of security, this material was not retained on the computer but was stored on compact disk with the audiotapes in a secure, locked cabinet. In addition, for reasons of confidentiality and security, each interviewee was identified by a single letter only. The key to identity was kept separate from the real names and addresses of the individuals interviewed.

Interview questions guidelines

The guidelines used were in semi-structured form, based on a general oral history instrument, used in the interviews of the original six re-analysed narration's, and the pilot study. They were initially adapted from work by Thompson (1988) and Yow (1994). (See Appendix Two). As a result of theoretical sampling (Glaser and Strauss,

1967), the guidelines were modified to reflect different lines of research enquiry as respondents were interviewed. The basic structure was used as a guide only and not as a rigid set of instructions. This allowed flexibility in following particular pathways. The specific experiences of individuals were used to develop modifications in interview guidelines for others as particular research trails were followed (See Appendix Three). For example, interviewee "L" spoke of the impact of the first voluntary services within St Crispin Hospital. The guidelines for "J", who was interviewed later, had specific questions inserted to probe the perceived role and impact of the voluntary services at that time.

The methodological advantages of sampling possible interviewees more broadly were demonstrated in an interview with a respondent originating from an area near Rainhill Hospital. A generalisabilty check was possible in exploring the recollections of this individual who spent her childhood living in public house premises nearby. An earlier interviewee had recalled patients mixing with locals in the public houses near St Crispin Hospital in Northampton. Exploring this subject in more depth in the interview with the publican's daughter provided a validity check.

Interview appointments

The nature of the approach to potential interviewees was as follows. Informed consent to interview was sought. This was initiated first in an approach by telephone when there was a brief personal introduction explaining the background, authorisation and objectives of the researcher. This was followed by a brief discussion on the broad aims and objectives of the project. The form the research process would take was then discussed. The intended interviewees were given time

to consider their response. If after a second call, they wished to proceed, information was posted to them or delivered through the door for scrutiny. If the interviewee agreed after this initial contact, a visit was arranged to discuss any further details.

As three of the new respondents for the main study were elderly, a brief introductory meeting was offered. They were advised that this might be in the presence of a third party chosen by them. For the same reason, the choice of location of the interview was offered to the narrator. All but one chose their homes. After an introduction, the researcher produced identification along with a letter of authorisation from the university. An effort was made to help the potential interviewee relax with general conversation before entering on to the subject of the interview.

At the initial meeting, both oral and written advice was given on copyright, confidentiality and anonymity. Potential pitfalls, such as with loss of anonymity because of recognition through well-known events were explained. The respondents were then given a further week to digest the verbal information and the literature before being contacted again to seen if they were willing to proceed. If they were, an appointment for interview was made. Every effort was made to avoid causing stress to interviewees.

The legal requirements and guidelines outlined in the Code of Ethics of the Oral History Society and the Statement of Ethical Practice within the British Sociological Association Guidelines were followed (See Appendix One: Basic text copies of documents approved by ethics committee review). This included an explanation of the interviewees' rights under copyright law and an explanation that interviews

would be audiotaped after the offering of a consent and release form. A release form allows the interviewer to share intellectual copyright with the interviewee and therefore use the material in research. The material may also be used for publication or stored in an archive such as the National Sound Archive. The interviewees participating in this project were able to stipulate conditions and limitations on the consent and release form as to what uses they wished the material to be put. The respondents were asked if they wished to decide the ultimate destination of their recordings (e.g. to go to the National Sound Archive or to be destroyed after the research process was finished). Their wishes were recorded on the consent form and initialled by the respondent. All interviewees agreed to the material being used by the researcher only, which included teaching. Respondents were also offered the chance to decide these questions later if they wished. Three interviewees later agreed to the material being given to the National Sound Archive. The curator of the archive stated an interest in receiving the material if the tapes were also transcribed. Complete copies of the three tapes, two by nurses and one by the retired gardener will be offered to the National Sound Archive with transcripts, research notes and copies of a consent form at the end of this research project. Consent will be checked again with the interviewees prior to this being done. In respect of the offering of a consent and release form, Yow (1994) advises that interviewees be informed that this will be done, prior to the commencement of interviews.

At the interview meetings, a consent form was offered and signed prior to commencing the tape-recording of an interview. Issues surrounding copyright and confidentiality, already covered in the literature received by the interviewee, were again explained. The interviews were organised to not last much longer than an hour

and a half. However, some narrators stretched the time longer of their own volition, and appeared to enjoy giving an account of their lives and opinions. In practice, one interview, the first in the earlier study, lasted for approximately two and half-hours. The shortest was approximately forty minutes. The average length of interview was approximately ninety minutes. The interviewees were informed that they would be given a copy of the transcript of the interview to study. Following the interview, the tape was transcribed and a copy of the transcript sent to the interviewee for approval. A copy compact disk or tape was also offered to those who wanted one. The interviewees were assured that if they were not happy with an interview, the tapes would be destroyed if they requested it. In the event, all were happy with the interviews they had given. Any comments as well as any relevant non-verbal responses during the interviews were noted afterwards in research notebooks. Parts of the recording they did not want used were omitted from the breakdown of the data. This only applied in one instance in respect of the respondent's uncertainty of recall. The respondent, as mentioned earlier, also supplied extra, clarifying, notes.

(8) Interview Schedules.

A schedule for an in-depth semi-structured interview was devised for each interview session. Issues that were raised and identified in earlier re-analysed interviews were followed further as part of the research trail using not only revised interview schedules but also other sources such as archive material. In using the process of theoretical sampling, data collection was "controlled by the emerging theory" (Strauss, 1987:39). A framework was thereby established (Bell, 1987) and used to develop the project. This contained main points only and was devised to prevent major "drift". During the course of interviews, it was found necessary to strike a

balance between making sure that areas of particular interest were covered while not stifling new and valuable information that might emerge. The first interview of the earlier research project of September 1997, which lasted for approximately two hours and thirty minutes, frequently covered areas outside of the time zone being studied. This happened largely due to a lack of focus in the interview by the interviewer. This was addressed in later interviews. An indication of the time that the interview was expected to take was given to respondents during the first meeting. They were also advised that this could vary depending on the progress of the event. It was felt to be important in helping the interviewees to plan their day and thereby provide an incentive to participate.

(9) Access to other sources.

None of the other sources contained clinical material of a confidential nature. They include:

- St Crispin Hospital non-clinical archives material and other archive material at Northamptonshire Record Office.
- Non-clinical archive material from the Towers Hospital and Carlton Hayes Hospital at the Record Office for Leicestershire, Leicester and Rutland.
- Northamptonshire Film Archive (accessed for a 1954 NHS recruitment film).
- Archive records in the possession of Rockingham Forest NHS Trust.

Old policy and other material, including a union minute book, from private individuals contacted by the researcher.

Notes on the data

An ideal data-set for the research would have been to have a more comprehensive coverage of the different perspectives involving St Crispin Hospital during the period chosen. As has been shown in Table One (page 117), the views of the nursing staff are represented through the re-analysis of the existing interviews plus one new one. The views of a previous medical director are also captured through interview. A variety of non-medical staff, including voluntary workers, a gardener and the daughter of a farm manager are also present as voices in the research. The review of archive materials and other sources implicitly draws into the analysis other actors including poor law officials, local councillors, union activists, as well as deepening the contributions from the medical and nursing hierarchies. The "voice" of St Crispin Hospital patients is, however, lacking. This influenced the decision to move beyond the immediate scope of a history of St Crispin Hospital as a place at a particular time, to consider the voices of other patients within different parts of the mental health system during the same period. This was achieved, as noted, by using the archived database of oral histories held at the National Sound Archive at the British Library in London (pages 107, 111-113, 115-116 and Table One: page 117). Although none were from St Crispin Hospital, the eight eventually selected were chosen on the basis that they had been in a psychiatric hospital between approximately 1935 and 1965 and were representative in respect of gender and ethnicity.

Even if a complete data-set for St Crispin Hospital had been achievable in constructing a more comprehensive history of time and place, this would not

necessarily tell us anything about the relative uniqueness or comparability of that hospital compared to other institutions during the same period. Therefore, where possible, some data has been drawn from other geographical locations. In each case this represents the barest of initial attempts to estimate the transferability of the concepts of community developed in the course of this research. Indeed, the interviews that prompted the initial insights into possible concepts of community that were re-analysed for this research were based not only on St Crispin Hospital but also on the Towers and Carlton Hayes Hospitals in Leicester. All three sources of interview data suggested the importance of community as an organising concept in understanding mental health provision. A further example applies to a new interview with a publican's daughter who was raised near Rainhill Hospital that represented but the first stage of testing the proposition that some patients mixed relatively freely with locals outside the institution itself. The archive material again covered both Northamptonshire and Leicestershire and at least within this moderate broadening of geographical scope there was nothing that would challenge the key concepts developed in this research. However, these represent merely tentative tests of the data, and further research would be required to test these propositions more extensively.

The development of an appropriate research methodology for the main study deriving from the experience of the pilot study will be described next.

(10) Analysing the interview data

The first three stages of the process were carried out using the facilities of a computer word processor, Microsoft Word for Windows 1997. The use of a

computer has been intended to make practical the thorough examination of a large amount of data and to reduce the possibility of missing important information. Along with sequential retrieval of segments in the order that they occur in original data, the approach offers many of the advantages offered by dedicated programmes, in handling large quantities of material.

(11) The sequential analysis of the interview data

A modified, five stage, sequential analysis has been used, based on a model outlined by Miles and Huberman (1994:87), reflecting on work by Chesler (1987). After the removal of obviously unrelated material, all interviews were coded during the following exploratory stages:

Step one: Each line of text in interview transcripts was lettered and numbered. This was felt to be useful following experience in breaking down the data in the pilot study. The initial, broad reference "start" coding meant that units could instantly again be traced back to source at any time by using the "find" facility under "edit", in the word processing package and entering the coding letter for the interview and the line number. The ability to find individual lines anywhere in a large mass of text by this means meant that data could always be kept in context by having the ability to reference back.

The text was next divided into "key" phrases and units of text that had, or appeared to have, some reference, either literal or descriptive to the nature of "community". These were separated. Descriptive "key phrase" data generated by interviewees was

coded in two parts differentiated roughly by date, from 1935 to 1950 and from 1950 to 1965. The reasons for this are:

- It emerged from these data, as noted earlier, that the beginning of the 1950s represented a watershed in the nature of the operation of St Crispin Hospital, in respect of management, environmental and treatment. Consequently, the contrasting "early" and "late" experiences could be confusing if not in some way differentiated.
- The year 1965 is felt to represent a logical, although flexible, end in the time parameters of the research in that by then the indications were that mental hospitals were eventually to close in favour of community care.
- Dividing these data along what has appeared to be a logical separation point made it easier to handle what has been a vast amount of information and make working it a simpler proposition.

In the initial stages of the research, the author hoped to study a much more extensive historical period of perhaps a hundred years from the mid-nineteenth to the mid-twentieth centuries. However, it became apparent that the period from the building of asylums until the period between the two world wars was a period of relative continuity within the institutions. To take one minor example of this, at St Crispin Hospital the strict segregation of the sexes, and the one relaxation of this prohibition in the institutionalised ritual of an evening dance, was held apparently on the same day of the week, at the same time, in the same hall, with the same ethos of the chaperoning of the respective sexes, from as early as the 1880s until the author began work at St Crispin Hospital in 1970.

The decision was therefore taken, to focus the study on the later stages of this time of continuity, and to concentrate the studies on the period after 1935. The end of the period studied was chosen to represent the time around 1965 after the policy decision to move towards closure of the large mental health institutions had been made, but where little material progress towards this purported goal had developed. Chapter Six does, briefly, take us beyond this period of study, but this is necessary to demonstrate the fuller expression of tendencies that were already within the mental health system by the nominal end of the period for this research, namely 1965.

Within the overall focus of the study, between 1935 and 1965, the data has been analysed in terms of two periods, 1935-1950 and 1950-1965. It should be emphasised that this is not a purely mechanical separation into two distinctive periods of time, with no interpenetration of issues. For example, concepts of risk that are discussed in Chapter Six were relevant to the earlier periods, though perhaps in a more embryonic form. The decision to analyse the two periods separately is both a matter of convenience in rendering the breadth of data more manageable and also reflects the conviction of the author that the period after the Second World War represents something of a watershed in mental health provision. As we will see, this period saw post-war labour shortages in mental health nursing services; the further medicalisation of mental health that followed the incorporation of such hospitals within the National Health Service; the rise of the voluntary sector as an agent of change; a cultural recoiling from large scale incarcerations that showed any parallels

with the dehumanising processes of concentration camps; and the advent of new classes of drugs used in treatments.

Details of these divisions in are demonstrated in Table Two next. This is an "at a glance" summary derived from data of the changes that related to St Crispin Hospital in particular.

Table Two: Aspects of progression St Crispin Hospital - 1935 - 1965

1935 – 1950		1950 – 1965
Basic "asylum" system remains in place. Beginnings of a more relaxed approach.	**Continuity --->**	Basic "asylum" structure remains but undergoing faster change.
Traditional approaches to care and containment. Largely ineffective treatments.		Increase in reforming initiatives by nurses, doctors and others. New treatments.
Wartime deprivation.		The National Health Service 1948 and increased funding. Strengthening of medical role.
A walled institution.		The walls are physically demolished.
Powerfully hierarchical structures.		"Open door" policies
Male nurse prison style uniform.		Male staff out of old uniforms and into "medical" style white coats.
A majority of patients still permanent residents. Some admitted voluntarily after the 1930 Mental Treatment Act.		1959 Mental Health Act. "Informal" admission. New appeals system.
New buildings for voluntary patients. Out-patient clinic.	**Disjunctive --->**	New "lodges" in the grounds.
Poor staff conditions and pay for nurses.		Poor pay remains. New care initiatives by nurses, doctors and others.
Weekly dances and cinema. Organised team games. Yard exercise and organised walks.		Founding of social clubs for patients (and staff - later including locals) with strong nursing input.
Locked doors and corridors.		Door unlocking in selected areas.
Male/female segregation.		Segregation begins to break down. Initially male staff working on some female wards.
Regimented de-personalised conditions.		Volunteers found the first "League of Friends". National voluntary organisations.
National MIND founded 1946		Hospitals marked for closure (1961). Emergent policies of Rehab. and community care from medically centralised institution.
Patient labour used on wards, farm, gardens and by hospital trades.		Less patient labour use.

Step two: Key phrases were re-stated as recommended by Miles and Huberman (1994) and coded into literal and descriptive categories, breaking the data up into clusters with common features. Units of narrative with distinct meaning were kept intact where possible. This approach was chosen after experimentation in the pilot study as it was felt that too much fragmentary reduction led to blurring of meaning in some instances and potential loss of contextual origin.

Step three: This was carried out using manual methods combined with the flexibility offered by a computer. Clusters were identified within the data. Categories have been developed for patterns and inter-connectivity between units of data. This process was repeated several times as new concepts presented. Data was moved and re-ordered in a similar way to what could, alternatively, be undertaken with a card index system. Analytic memos detailing possible theoretical insights, as recommended by Glaser and Strauss (1967), were also kept. One such memo related to the emerging notion of the significance of the early amateurs who began work in the mental health arena in the immediate post-war period and contributed finally to the sophisticated voluntary structures that exist today. Memos were written onto a wall-mounted flip chart for easy visual reference.

Theoretical propositions were identified within the data. It is acknowledged that although a computer can automate some processes it cannot replace the reasoning of the researcher (Burnard, 1994). It is felt the contemplative perspective offered in working the data manually at the later stage is best.

Step four: Major or "core" themes within the proposition categories created from the data were identified. These were intended to tie together in a broad way the meaning conveyed. A major core theme that began to emerge during the period when changes within the hospital communities were beginning in the 1950s was the gradual re-emergence of the patient as an "individual". Some aspects of this process appeared to begin with simple interventions such as the sending of birthday cards by volunteers and developed with such innovations as personalised clothing and boutiques.

Step five: Interim explanations concerning influences on community as interpreted within the bounds set by this study were formulated. One such explanation is the conceptualisation of the mental hospital in the past as a Geographic-Occupational Community, not separate, but as part of a work community incorporating the local centre of population. These were developed into theoretical constructs as demonstrated next in tables Three and Four.

Table Three: The Theoretical Construct of the "Geographic-occupational Community"

Concept	Category	Theoretical Construct
Acceptance Understanding Familiarity Locality ...Work (inc. hospital employment) ...Services ...Socialising Staffing (inc. hospital residence) Extended local "staff" families Club activities Sports participation Public houses	Feeling a tolerant environment "Old village" "...a good rapport"	The nature of a "Geographic-occupational Community"

Table Four: The Theoretical Construct of the "Community of Interest"

Concept	Category	Theoretical Construct
Experiencing (e.g. patients and ex-patients)	Participating	The nature of a "Community of Interest"
Supporting (e.g. relatives and carers)		
Being interested		
Used in the service of other people (public service)	Volunteering	
Contributing (e.g. local artists)		
Reforming		
Complaining		
Helping		
Looking after		
Looking 'in' (and observing)		
Understanding	Educating	
Changing		
Broadcasting (e.g. television documentaries)		
Informing		
Interest group working (e.g. MIND and non-statutory service provision)	Providing (inc. non-statutory services)	
Developing charities		

(12) Documentary archival material.

Documentary and other material was utilised in the development of theory along with data derived from oral history interviews. The material has been described briefly earlier in this chapter and will now be described in more detail. It includes archive material taken from the records of St Crispin Hospital in Duston, Northampton. Following the closure of the main hospital building during the 1990s, the records were transferred to Northamptonshire Record Office.

Permission to access this material was extended by the Chief Executive of the Northamptonshire Community Healthcare Trust following earlier agreed access granted for the pilot study. Some of the material remains un-catalogued and is limited and mixed in terms of depth. No clinical records are available however (and would not have been sought for ethical reasons). Many of the documents have time limits for release that can be as much as forty years. There seems to be little uniformity on this policy between different areas of the country. Leicestershire Records were more openly accessible.

Other material that is in private hands has been accessed based on personal networking. It seems that before any central decision was taken as to what to do with much of the material, it either languished in storerooms or was removed by departing individual members of staff as personal mementoes. The documents accessed from this source include trade union records in the form of a minute book for the Confederation of Health Service Employees between 1956 and 1974. This is now in private hands and has been received on loan. Other material includes an early copy

of hospital rules and regulations, pamphlets relating to hospital events, a procedure book and various textbooks including nursing "red books".

(13) Photographs and film.

Photographs and film have been utilised during the study. The provenance of photographic material can be a problem. As acknowledged by Banks (2001:14) there have been questions about the importance of the filmed and photographic image in social science research while nonetheless recognising it has some value. Among problems that might arise in relation to photographs in particular are the following:

a) Where was the image taken?

b) Who is in the image?

c) Was it posed or not posed?

d) When was it taken?

e) What were the circumstances of the picture being taken?

f) What was the relationship between the photographer and the photographed? (e.g., Are there issues of power, coercion etc.?)

g) Has the photograph been "cropped"?

It is further noted by Banks (2001:40), that "still photography, an apparently objective mechanical recording medium, can be ambiguous in its capacity to 'document'". The images used in this study have a full history attached by those who have provided them, or have a history from other sources. One or two have details written on the back.

Although the problems outlined above are important, such images are useful in illustrating certain aspects of the development of theory if used with other sources. In mental hospitals during the period being examined for example, photographic records were sometimes taken of communal activities such as football matches and the teams that played in them.

Moving images on film and video also provide problems as outlined above, as well as others of their own. A silent film used in the research, although scripted, can still provide clues to some aspects of the society in which the actors lived.

(14) Conclusion.

The study described is for an exploration of the nature of community within a defined historical period – 1935 to 1965. It uses a qualitative approach and is multi-method based. The intention has been to be both flexible and grounded. The experience gained in the pilot study and adaptation of changes during the main research process has shown this approach to be effective. The methodology provides a way of studying the way in which individuals involved in mental health at the time in question recall their world, their situations and the social meanings of their actions in relation to concepts of what "community" meant to them. This has provided a rich source for the author to develop a theory of community supplemented by documentary and other evidence. The latter, on its own, could not have provided the same understanding.

This chapter included appropriate literature referring to both theoretical underpinning and methodology, which was critically appraised. The theoretical basis of the research into conceptualisations of community was critically explored. This process examined an oral history approach combined with other sources. The development of an appropriate research methodology was critically appraised in light of the research experience. A description of the structure and development of the research procedures used was given and their strengths and weaknesses revealed during the process discussed. This included tactical developments adopted in the light of experience. An example of this was the decision to focus the research on a period after 1935 and up to 1965 when it was revealed as an important time when many changes took place. The methods adopted to gather, analyse and develop data were included. The development of a pilot study and its outcomes were described first, followed by a similar methodological account for the main study. Chapter Four will begin the description of the interpretation of the data. Where they help to illustrate the analysis, photographs have been included.

CHAPTER FOUR

VOICES ON MENTAL HEALTH COMMUNITIES: 1935-1950: The "Geographic-occupational Community".

Introduction.

While there is a considerable literature on the history of mental health legislation, hospitals and other services during the watershed period being explored, the nature of the relationships between individuals who composed the structures of the communities in and around the services are only recently being more fully examined. This applies in particular to those personally involved and with respect to the differing perspectives of the positions they occupied. They reflect wide contrasts of influence in the hierarchies of staff and patients.

The use of semi-structured oral history with other sources has provided evidence of these different perspectives in the conceptualisations of community in mental health during the period between 1935 and 1965.

Emerging themes have been organised within two periods. The first explores the period from approximately 1935 to 1950. The second period, between approximately 1950 and 1965, is analysed in Chapter Five. However, these time frames are not hard and fast, for there is reason to believe there may be a continuation of practice from an earlier time and/or continuation into a later time. The changes that took place during these two periods are not demonstrated to be distinctly separate in a mechanical sense. There is evidence of a period of deprivation and poor resourcing during the Second World War, however and of particularly significant reforming

developments at St Crispin Hospital from the early 1950s onwards. Taking these factors as a guideline, the division of the data in this way also makes the chronological organisation, of narrative in particular, easier and more logical.

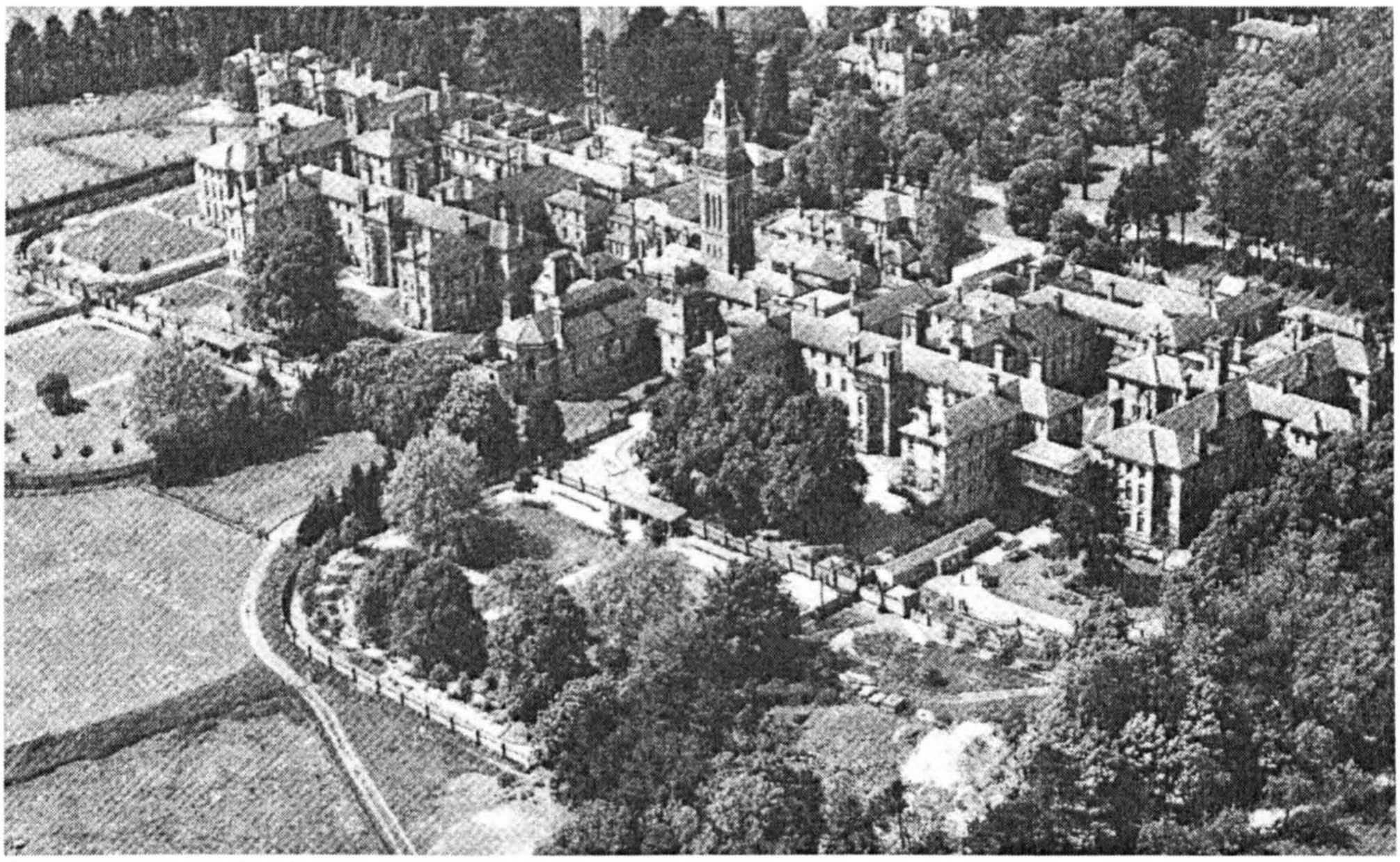


Figure Two: St Crispin Hospital (probably taken during World War Two). The walls can be clearly seen.

Some of the changes in the mental health system before The Second World War such as, for example, legislation, treatment initiatives and building provision have already been recounted in Chapter Two. In addition to these changes, other themes emerge from the data contained within the interviews conducted. What is significant, however, is that throughout this period, the general institutional approach and commitment to care and containment remained relatively consistent until the 1960s.

This chapter will explore the following core elements arising from the data:

(1) Communities within communities – hierarchies within hierarchies.

(2) Communities of choice?

(3) The bounded community?

(4) The Geographic-Occupational Community – "Old Village".

(5) The enclosed concealed community – work and the long-stay patient core.

(6) Recruitment and the musical and sporting tradition.

(7) Communities within Communities – the gender divide.

(8) The recruitment of staff from "outside" communities.

(9) The post-war crisis.

(10) Conclusion

(1) Communities within communities - hierarchies within hierarchies.

An exploration of the data has provided results that give a vivid portrayal of the working of the pre-war institutions. In pre-war years County Mental Hospitals existed alongside Work Houses and generally served the same "pauper" population, although the former occasionally admitted a few "private patients". Patients admitted both during that period and later often saw themselves as being "put away" in what was seen as a process of removal from general society to isolated areas. An ex-female patient recounted her concept of the old mental hospital as being a place both removed from and serving local areas.

> *P. "... because you know in the old days... of... hospitals were away from... you know... where the... big hospitals were away, you know, such as... likes of... institutions and asylums, and I went to Cane Hill, because I took an overdose at Farnborough..."*

As a patient, "P" would have had little choice about her admission and would have entered an institution with a well-defined culture, social and organisational structure and with clear rules of behaviour. Within the institutions, work was organised around routines and closely supervised by a powerful hierarchy of individuals. The hierarchy was recognised by all, from patients to medical staff.

At the top of the hierarchy was the Medical Superintendent and his approach (for it was invariably a male) determined much about the nature of a particular institution. His power, along with other senior figures, was far-reaching. As recalled by "I" who grew up within the grounds of St Crispin Hospital in Northampton and was the daughter of the farm manager:

> *I. "Well, I think the.. the Medical Superintendent was...was very respected everybody felt that he was really in charge ...and of course the ...Matron and the...Senior Male Nurse."*

One respondent, a doctor who began work in mental health at the end of the Second World War, remembers the Physician Superintendent as follows:

> *J. "...Firstly he... he was ....he was the boss doctor. He took final responsibility. Initially when I got there first he signed all the letters that went out. All the letters...about patients and so on ...He maintained a regular contact with the Matron and the Chief Male Nurse...met them every morning...went through the ward reports with them...interviewed any...of the nursing staff with the respective Chief Male Nurse or Matron if there were problems... involved with the...The Farm and The Engineers and The Paint Shop or..."*

The general administration of the hospital was nominally under the control of the Clerk and Steward:

> *J. "The Steward of the hospital was virtually the... sort of boss Administrator ... but he answered to the Super...The Superintendent."*

The Superintendent himself was answerable, to a Committee of Visitors or Management Committee and had to endure periodic inspections from the Commissioners of the Board of Control, a body that had taken over all powers and duties of an earlier body, the Commissioners in Lunacy under the terms of the Mental Deficiency Bill of March 1913. Apart from that, he had a fairly free hand. The Committee of Visitors also reflected the dominant social hierarchy, of the county, in the case of St Crispin Hospital:

B. "...they sat once a month...and... and.. the man who was the king pin of course was the medical superintendent... there would be persons there on the committee from the staff relating to the financial side of things etcetera, etcetera, for supplies etcetera but the majority of the committee were all lay persons, all of the county type, you know... there would be the chairman of the... and he would be... well I know on one occasion, I mean, Lord S, I mean he was... a chairman...Lord H... was another man and various other people.. some of them..... but by and large, they were county people, farmers and all this sort of thing."

The hospital itself was, in many respects, a microcosm of the traditional and deferential county squirearchy within which it was situated, and from which many members of the committee were drawn. Recognising "your place" in the structure could be considered a virtue at that time.

Below the Medical Superintendent was a complex extended hierarchy that permeated all layers of staff and patients. The layers of hierarchy below the Medical Superintendent contributed to a system whereby the routine-based working day for patients and staff continued little changed from the time one hospital (St Crispin) first opened in the 1870s. For male nursing staff, etiquette demanded certain practices that continued until the early 1950s at least:

F. "...some of the charge nurses I... have worked with, you know, when they came on in the morning, you daren't say boo until they had their cup of tea and...and then yes...but that you always had, sort of it's...you never called them by their Christian name, it was always 'mister'...you know, always by 'mister'..."

Among the nursing staff, there is evidence that hierarchy was also reflected in appearance. Both the male and female staff wore uniform. While female staff wore uniforms in the same style as general nurses, males wore an outfit similar to a prison officer:

C. "I wore a uniform with brass buttons, it was like a police or a warder really...a warders uniform with a tunic and a pair of trousers and brass...well

silver buttons with the words 'Berrywood Mental Hospital' on the brass buttons with collar and tie...a peaked cap...very, very much like a prison warders...and a bunch of keys...at that time, the larger the bunch of keys, the more important you were...(laughs)"

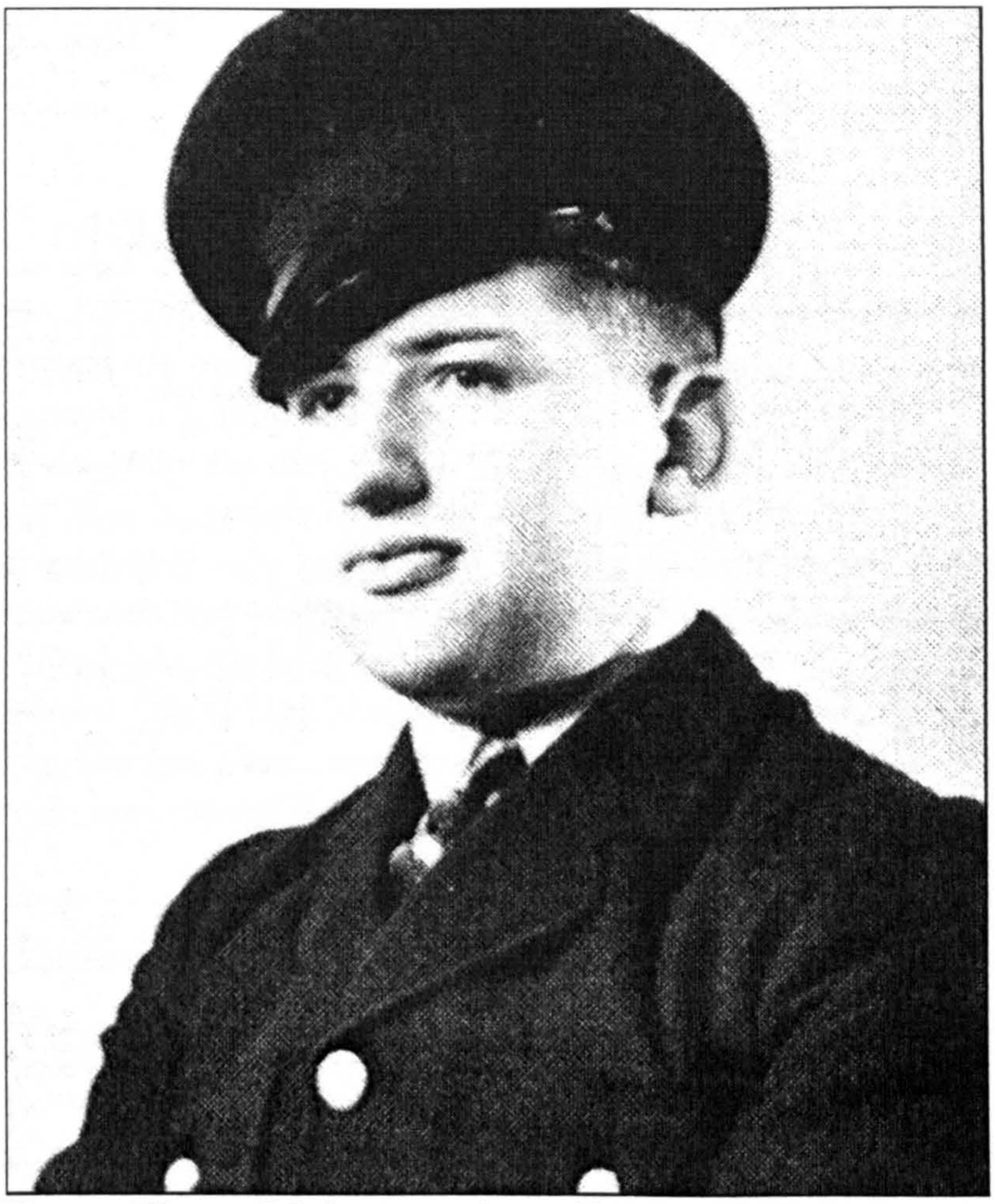


Figure Three: Male nurse in uniform - 1940s

Rank was important and denoted by identifying details such as rings of braid as a student male nurse who began in the service in the 1930s remembered:

> *"The staff nurse would have one ring which had a run of braid around the wrist...with a ring on the top, rather like a lieutenant in the navy but it was black, the same colour as the uniform, or navy blue. The second...when you became a staff nurse, you got your ring. If you were a deputy charge nurse you would have two rings and if you were a charge nurse, you got three rings and if you were chief male nurse you got four rings you see..."*

The uniform for the male nurses was not dissimilar to that of a prison officer. It denoted authority and rank, as recorded above. Archival data reveals that a uniform of this type had been used within the hospital since it was founded in the 1870s. It

was still being used in the 1930s and did not vanish until the 1950s. The only changes had been adjustments reflecting changing fashion. Appearance could influence attitudes and thereby the nature of the community. This could also be gender specific. For example, "B" a male nurse who began work in the 1930s recalls:

> *"...but the thing about it is that you also have to remember that personalities come into this as well. So however you were dressed, then quite obviously, I mean if you have a good natured type of... attitude to life and indeed to the patients themselves then, you get along all right, there's no doubt about that and indeed, you know, a sort of friendship grew up. Now having said all that, you also have to consider the way the nurses were dressed, the female nurses I'm talking about now and there they were in their lovely white aprons and their blue belts and their nice white caps and so on and so on. Everything about it suggesting that they were nurses in every sense of the word. All-right let's go back to Florence Nightingale and you know and there we are and... this is it. So therefore I think that... male patients may well have considered us to be more authoritarian than...maybe the women patients felt about their nurses and you can understand that."*

These data reflect a pyramidal structure of grade and authority within the geographic area of the monumental and originally grandiose Victorian institutions that were still in existence in the 1930s. The overall impression revealed by the data is one of generally stable functioning at St Crispin Hospital in the pre-war period in a more or less continuous process, in form and structure, since the institution was founded. Any improvements such as new legislation and new buildings, such as, for example, those constructed to accommodate voluntary patients, served to refine the institutional model of care and containment. The hierarchical structures were partly defined by social position and appearance. At the top of the pyramid was the Medical Superintendent. His authority could be argued ironically to have been recognised, in part, by the fact that he was not required to wear a uniform. At the bottom and subject to the authority of all were the patients (or inmates).

Control of clothing, of how an individual presented within the community of the hospital, was under the jurisdiction of the institution both for involuntary patients, as well as for staff through their uniforms. For patients, clothing was provided by the hospital and issued from stores on the wards. It was not personalised in the sense that it was centrally issued and choice was determined by the influence or preferences of a ward sister or charge nurse. This system even applied to footwear. A male nurse "B" who began work at St Crispin Hospital in the late 1930s remembers one aspect of routine:

> *B. "Boot cupboards was a system yet once again whereby the patients had shoes for in the wards and then when they went into the exercise yards, they put boots on. So it was my job to go up to the boot cupboard to unlock the boot cupboard so that the patients could then change their boots, put their shoes on and so on and so on."*

In addition, all other personal effects such as toothbrushes and soap were under staff control.

For those patients who were considered to need control and restraint, clothing of a very different kind was remembered by a woman who had been a patient at both Cane Hill and Horton Hospital. This testimony implies that clothing and therefore appearance not only denoted position within an institution but also was itself used as a means of direct physical control as well as social control.

> *P. "... no... you went into a strong dress after you'd been in a straight jacket... that was... you know... one step up the ladder, sort of thing... and I think they used to... the strong dresses used to come down to here... but the straight jacket... oh, it was terrible. You were... buckled in, you know..."*

The Handbook for Mental Nurses (1946:453) defines restraint as

> "...the restriction of the bodily movements of a patient by any appliance whatever, such as a sheet, bandage, towel, straight waistcoat, strap or pack.

> Such restraint, of course, must never be applied except under medical order, which specifies both its nature and duration."

Uniformity and its effect on the individual applied to more than clothing whether for staff or patients. In describing Severalls Hospital Gittins (1998:45) notes that admission should not be a "life sentence" but:

> "The whole elaborate hospital system, however, including hierarchy, bureaucracy and a spatial design that encouraged regimentation and institutionalisation rather than rehabilitation, combined with well-entrenched prejudice at all levels of society, and most important, chronic underfunding, meant that such ideals were not easy to implement."

The Severalls data is supported by that obtained from St Crispin and one respondent from there also referred to the possibility of "a life sentence" for those admitted before the advent of voluntary admission after the 1930 Mental Treatment Act.

It is important to remember that there was no effective drug treatment or talking therapy available at most institutions in the pre-war period.

> *J. "...and of course this...this was ...before any...any of the tranquillisers or anything like that. There was Paraldehyde and Phenobarbitone and ...Barbitone ...Oh yes, 'straight' ECT...."*

The only medications available were drugs such as Chloral Hydrate that were sedative in nature. However, the introduction of some new treatments during the 1930s, may have had an influence in stimulating change both within and outside mental health institutions.

The management of "risk" in the Geographic-occupational Community.

There is no mention of the word "risk" in the index of A Handbook for Mental Nurses (1955), the so called "Red Book" that was the standard tome used in the

training of mental nurses at that time. Conversely, "risk assessments" are indexed in "Mental Health Nursing" (Wright and Giddey, Eds., 1993) and also in "Stuart and Sundeen's Mental Health Nursing" (Thomas, Hardy, Cutting, Eds., 1997). This is not to say that the avoidance of potentially dangerous situations was not a prime consideration at the time of the institutions. In fact, it is argued, that social control and the avoidance of danger, or risk, within the institutions was part of their very structure albeit within an enclosed geographic area. A major difference is revealed as being in the nature of the elements of control that were largely social, cultural and, in particular, physical. As has been revealed, the institution was walled and within the walls were other levels of confinement largely based on conformity or non-conformity of behaviour. Conformity of behaviour could lead to the privilege of greater freedom to roam within the institution grounds or local neighbourhood. It could also lead to other privileges as will be revealed later in this chapter. Failure to conform, to the degree of presenting any sort of threat either to their own or another's safety, could lead to various degrees of confinement, either within the locked environment of a ward or in more extreme cases, even closer confinement within a refractory ward. Within a refractory ward, further isolation could be enforced by seclusion within a strong room. As described by the narrative evidence provided earlier, there could then be even further restriction with the use of "strong" clothing or even mechanical restraint. Allied to confinement were rigid policies of various levels of observation. Later archive material from 1974, at St Crispin Hospital, records a reminder of the importance of observation and scrutiny within the institution and was provided by the Principal Nursing Officer:

> "In consequence of the recent influx of new members of Nursing Staff, and the number of patients who are under Special/or Close Observation, it is essential that Ward Charge Nurses and Sisters ensure that all members of the ward team

> are aware of the standard Procedure for nursing these cases." (Archive material - 5/7/74)

Such policies are still used in in-patient units where confinement within a ward or unit are used for those considered most acute. In addition, the rigid hierarchical structure of the hospitals revealed within the data and the clear lines of authority hint at the levels of control obtained. The ritualistic and even military nature of working practices imply that these were places designed to stop what may have been seen as dangerous events from happening. The physical appearance of staff and patients relating in particular to uniforms for nurses reflect an emphasis on authority. Also, the total control of the patients lives even down to the non-ownership of clothes or even toothbrushes can be interpreted as a depersonalising element ensuring total dependence with a nudge towards conformity. It is hardly surprising that the problem of "institutionalisation" among patients, and it is argued some staff, became a cause for concern when the problem arose of how to close the institutions.

At the time when such geographic-occupational communities as mental hospitals were in their prime in the pre-war period, physical forms of containment and restraint with limited, largely sedative drug use, were seen as the only options. The contention outlined by the research is that what is now so prominently defined as "risk" has always been present in mental health but was dealt with in a different way reflective of the times. The fear of the "dangerous" sufferer from a mental illness could also be said to have been enhanced by the methods used to house and manage the mentally ill. In other words, if a walled institution and uniformed attendants were required, there must have been a good reason. However, there is evidence that the "old village" local to St Crispin hospital provided a relatively tolerant contribution to

the occupational community, of which the hospital was a part and it will be explored later in this chapter.

The highly restrictive nature of the old institution was to begin to change with periods of therapeutic optimism, first in the mid 1930's and then to a much greater degree in the post Second World War period. The demise of the mental hospital "geographic-occupational community" and the evolution of the "community of interest" will be explored in Chapter Five. Likewise, in Chapter Six, the development of the "risk community" will explore the changing nature of what is now called "Risk Management" as conceptualisations of what is community adapt to social change.

Goffman (1968) has provided the classic account of how normal living patterns and characteristic means of identity were defined within the life of mental hospitals. The activity of living was communal and imposed within a hierarchical system divided between staff and patients. Those patients admitted before the Second World War may have expected to stay in for long periods. This was unless they entered as one of a new class of "Voluntary Patient". For many, there was no choice:

> *O. "I was walking about with my people... riding about, going down to Littlehampton, Newcastle and places that you see... until the doctor sent me into hospital... and then of course I was in... in for life then... of course because... I didn't know what it was about for years like..."*

"Certification", the infamous process arranged by doctors certifying a patient as insane, perhaps against their will, was often seen as a last resort and carried a stigmatising effect. As we saw in Chapter Two, a number of authors including Skidmore (1994) and (Plant, 1974), argue that extant concepts of community entail elements of choice and wishing to "belong" as being important elements comprising

the construction of a sense of community. The nature of involuntary incarceration provides a challenge to these social constructionist perspectives.

(2) Geographic-occupational Communities of choice?

The notion of community as being partly one of choice for the individual was discussed in Chapter Two. The relatively unique nature of mental hospitals during the pre-war and immediate post-war periods (along with prisons), where the inmates were coerced, or many may have been in the case of the former, does not fit well with this theoretical interpretation. The evidence of the oral data produced by this research is that although, for some staff at least, the feeling of community was strong, for patients the experience was predictably very different. First, the element of choice did not exist, although the experience of hospitalisation was not totally negative for all. The question as to whether psychiatric hospitals were communities or not, which would support or alternatively challenge the hypothesis of "communities of choice", is very relevant. This research finds that the concept of the "geographic-occupational community" accords better with the data. Patients were admitted, often under a Section of the Mental Health Act 1959 with very little say:

> *O. "`Oh no, there was no choice, you went straight in... straight in the hospital, you... you found your ward and that sort of thing, and they went on with it, best way they could and... but... I was in... like... Fourteen Ward mostly. My people used to come and see me every week you know... yeah... yes, that's how we..."*

An ex-patient of Napsbury Hospital had described the experience of being born in one of Stalin's gulags and equated it to his experience of the mental hospital:

> *M. "I was born in these extreme conditions of deprivation, which later on was... in a paradoxical way, was to serve me well to survive the psychiatric*

system...because, it seemed to me that...there were some horrible... similarities...between the slave labour camp where I was born...and, the so-called mental hospital where I was allegedly treated."

One ex-patient, "S", recalls her shock on admission and in particular, the nature of the mix of residents on the ward she was sent to:

S. "So we, we've got this row of old ladies and under some of the chairs there's puddles of urine which obviously the smell that goes with it and there's just this big, very big room..."

S. "Yeah. I think the, the one word that sums a lot of the feelings up is that I was absolutely desolate. I felt abandoned, I don't know who I felt abandoned by but I felt I'd been abandoned to whatever was going to happen to me. I was frightened and the locked was, was a lot of it. The, the, the fear of being locked in and having no options and no way of getting out, no choices, the choices were made for me and it was, yeah, I was frightened. And the, the sort of, the things, the things that followed, it was, in those days it was, it was, sort of, they had a routine which had to be followed, whatever."

Being strongly encouraged to participate in some activities however, did not with some ex-patients necessarily mean a negative view was always retained:

P. "... but if you go into a psychiatric hospital, nine times out of ten, a lot of people they either start because they're... particularly today now, because they're bored. There's nothing to do... you know. They say there's all... you... you're not forced... made to do anything. Everything is your choice... you know what I mean? And I think sometimes, the old ways... you know, where you were sort of... pushed into doing things... I don't mean to say you should be pushed in a regime, like they were years ago, but to be encouraged more, you know... in that... on the stricter line to do these things, it does help you."

Therefore, although hospital admission might have been compulsory, there was an element of choice in respect of the degree of participation in general activities. In some respects, "P" felt that the old hospital community was preferable to care in the outside community, whilst at the same time stressing an unwillingness to return to those times. However, this does reinforce the view that to live outside of hospital does not necessarily mean acceptance and a better quality of life. In this instance "P", the female ex-patient had also experienced compulsory detentions.

"P" retains some positive opinions about the old system. However, the current level of scrutiny she experiences in the community and the uncertainty caused by an ever-present threat of a further loss of liberty mark a distinct shift in the form of governance she feels herself subjected to:

> *P. "... they live in the community now and really hospital has nothing at all to offer me, nothing at all, and oddly, years ago, even though I am critical of the system in so many ways, it did in fact have more to offer. And there are, I know in my own personal knowledge, people who feel very much like me, that we wouldn't wish to go back to what we had but we would wish for more than we have in the community because Care in the Community in some ways doesn't seem to exist. It's very patchy throughout the country, some areas are better than others, but in this area, I mean, I can have a social worker and a community psychiatric nurse come to visit me, to offer, you know, support, somebody to talk to. If I weren't very well they would come in on a pretty regular basis but I, I know that part of what they're having to do, we're not being critical of them as people, it's the system again. I'm being policed and I don't like that. I'm being policed and they're, they're waiting for the point where they feel 'Goodness, we've got to take her into hospital, she's really quite ill' and that's not what I want."*

This evidence supports the assertion made in Chapter Two (page 81) that life for some in the community outside the old institution could lead to some degree of loneliness and isolation. There is also a difference between having the constant support of an understanding community around and then, with community care, getting a response from the "policing" professionals when the situation begins to deteriorate.

The loss of feelings of individuality during day to day institutional existence in this period related to the simplest elements of life, including what was eaten as well as what was worn.

> *P. "You didn't have a choice. You didn't have a choice at all. Yeah, I think you had... porridge... [pause]... I don't even think... I think... it wasn't the*

milk like you have today. We had porridge and milk... I think... mug of... out of this great big tea pot of tea, you know... and that was it... and then..."

For the patient at least, the issue was often not one always of joining a hospital community through choice as a willing and active participant., Nonetheless there are elements of this earlier form of governance that are, in some ways, felt by "J" to have been preferable to the service now. Although current scrutiny of her position is now from a distance, she continues to find it an uncomfortable presence..

Others saw things differently after many years of institutional confinement. There was often resentment at the loss of years of an individuals life involved. Born in Asia in 1937, "T" came to England in 1958. His first admission was in the mid 1960s and he also spent time in prison:

T. "But I just didn't like being in hos... in a mental hospital for all those years..."
"I considered them as wasted years of my life, wasted years. Not being able to play cricket, not being able to live in the community, with all my friends around me and my family around me. So I was quite bitter that I had spent many, many years in mental, two mental hospitals and prison sentence because of my mental health..."

He sees his new life outside of hospital as being of a better quality than during the years of confinement:

T. "I would like to say that I'm much better now than what I was, because I'm not in hospital any more. I'm in the community now. I can walk up the High Street, go shopping, buy clothes, have a coffee out, go to the Indian Restaurant for dinner, go to the pub with a friend of mine for a pint of coke."
T. "The, the, the fear, the fear of being in hospital made me think, of being in hospital made me think I would die, but when I got my discharge I wanted to live, in the community again."
T. "... Live in the community, and not be institutionalised, and having to go back, or wanting to go back to mental hospital which is not very nice, dreadful thing to be in mental hospital."

For individuals with an enduring mental illness therefore, the nature of the care they receive and have received in the past has not been always been based on choice. Despite the introduction of the categories of "voluntary" and "informal" admissions, the threat of compulsion has always been present had they refused. This was (and is) the case even if patients had agreed to informal admission and wished to leave. The key element in compulsion is the hypothetical need to protect the safety of the individual and others. This is an essential element in considering the evolution of "risk assessment" centred policies of today. The genuine choice that individuals had after admission was whether, questions of security permitting, they chose to adapt to the life and activities of the institution.

This brief review of data does not fully resonate with a conceptualisation of community that relies strongly on an element of individual choice as outlined in Chapter Two. It implies that such a model does not fit when considered in respect of mental health services, either when applied to institutional care or, for that matter, in policies of scrutiny and supervision applied to some being cared for in the outside community. These issues do not bear out the concept of communities being formed necessarily by participants who accept a stake in their establishment willingly. It refutes a conceptualisation of community outlined in Chapter Two with reference to Skidmore (1994), who argues that communities are personally defined with a dependence on creation and construction taking place because of the wish of the members to do so. The data demonstrates that although such a definition may apply to "care within the community", that will be explored later, it does not "fit" with the compulsion of historic mental hospitals, their form of functioning and their surrounds. A fuller explanation requires a different theoretical perspective that takes into account this apparent contradiction.

A theoretical concept of the Geographic-occupational Community is a different perspective that throws some light on this issue and appears to reflect the data in relation to St Crispin Hospital in particular. It is a concept that does not appear to have been widely applied to mental hospitals and their associated populations before. This will be explored during the course of this chapter.

In addition, the evidence supports the contention that the word community is rightly defined in a number of different ways and does not appear to have one clear, accepted definition. This supports the contention outlined in Chapter Two that for all its present day use in government policy and other literature, the concept of community is "complex", abstract and "usually unanalysed" (Minar and Greer, 1969:ix). It supports the argument put forward in this thesis that analysis of the structures and circumstances in which definitions are used must be a basis for understanding. In other words, one concept does not fit all. There is no single definition of "community".

Nor does a model of community so heavily dependent upon choice fully explain the extent to which mental health staff and patients were integrated into the local geographical and work communities of which they were a part. The result indicates, it is argued, that the concept of a geographic-occupational community, within which patients received commodified care and containment, sits much more easily with the data. Such a model does not imply choice for the patients as being a central tenet. Also during the pre-war years of the strongly hierarchical rule of the medical superintendents, staff options in varying care initiatives to the patients that may have

involved a more progressive approach, can be inferred to have been difficult when institutions operated within a stultifying regime of routine and protocol. As will be noted later in this chapter, there is archive evidence that not all ex-members of staff were happy with the breakdown of the traditional structure of the institution. The institutionalising effects of the regime on the patients must also have had similar effects on some staff who would have felt more secure and comfortable within a clearly defined structure

Although many patients undoubtedly adapted in creating a sense of place for themselves within mental hospitals, and indeed may ultimately have found it difficult to leave, nonetheless they may have eventually been resident for most of their adult lives. Large numbers never emerged and many received "paupers' burials" within the grounds of the institutions.

Mental Hospitals as "communities?"

The issue of "choice" in the construction of a community raises the question as to whether mental hospitals can legitimately be conceived of as "communities". Some staff certainly did perceive them as such. A male nurse, "C" working at St Crispin in the pre-war period had followed his father into the profession. He ultimately achieved a very senior position, and spoke positively about "community". However, in taking into account the views of individuals, whether patients or staff, issues of external validity must be considered. This is because it is highly likely that those who stayed, and succeeded are those more likely to have been content with their lot. The voices of those who were not happy, did not derive any sense of positive community, and who may therefore have left, are by definition absent from these

accounts. Thus, it is those who stayed and helped construct the society in which they existed whose accounts remain accessible to the researcher. In reflecting on his early experiences, the male nurse first considered life within the institution itself:

> *C. "...I think that the camaraderie in the hospital, in the community, the hospital community and the loyalty to each other as well as to the organisation was something that I think attracted everybody. I mean the place had a wall round it but there was a community within that wall and they were the engineers, there were the painters...there was the office staff...there were just a couple of doctors in the early days...there were all the nurses, the male nurses on the men's wards and the female nurses on the other side of the hospital looking after the ...looking after the women...but the sense of...of camaraderie was as I say outstanding. It,... I suppose...it was a very difficult job, it was a demanding, demanding job, long hours and in a difficult environment for much of the time...not too much too stimulate you, so that brought out everybody's attitude to each other."*

The perception of this individual also included a consideration of the attitude of the wider local community:

> *C. "...there was practically no links with other hospitals at that time. That came, in the sixties and we could perhaps talk about that later, but at that stage we were very, very much a community and the majority of the population of Northampton really saw it as an isolated unit where people who were mad were taken to...Very, very few people were discharged in those days. Just a few but not an awful lot were discharged and so it was thought best very often to...to forget these sad people that were put into the asylum and the only people that really had understanding were the Duston people..."*

The mention of "Duston people" as having a special understanding with regard to the patients within St Crispin Hospital is important and is a suggestion that the boundaries of the hospital permeated beyond the walls in the notion of "community". At the time being described, the period up until the 1950s, the hospital had been placed within the same village environment, on the edge of Northampton, for approximately eighty years. It had then developed within this geographic location and become very much a part of it.

As well as the possibility that the feeling of hospital community existed beyond the walls of the institution, there is narrative evidence that, where some of the staff were concerned, there was a perception of a community within a community. This not only involved camaraderie among the staff but included the familial nature of the relationship between them and some of the patients. A reference to the fact that many patients were isolated and no longer visited by anyone who had know them in their earlier lives, was taken up by "D" a female nurse who had begun work at Carlton Hayes Hospital in the 1950s:

> *D. "... I don't know that I meant it as a family relationship, but it was ...it was a relationship... it was the only person that that patient.. a lot of the patients didn't see families, didn't get visits because ... you what you have to remember is that Carlton Hayes was the county hospital so patients could come from miles away where there probably wasn't any transport for relatives to get to the hospital on a regular basis and if... if they could get it was probably by taxi which would cost them an arm and a leg you know, they'd probably have to save up for two months to pay for it so the nurses were all the patients had got. So you sort of like stood in for their family I suppose really."*

A man born locally to St Crispin Hospital, at Duston, spent his complete working life there. He began initially in a junior capacity on the hospital farm and eventually became Head Gardener. This interviewee also provided evidence of a feeling of community within the institution:

> *G. ".... everybody was all friends and matey you know and we...it well I mean, I'm said people have said to me 'what was it like working up there years ago' and I've said well the best description I'd have said was just like working in heaven to me up there you know?...."*

The evidence in the data is strong in that long-serving members of staff certainly felt mental hospitals were viable communities, even though many patients, were reluctant inhabitants, whose incarceration may have continued even after recovery from their mental illness.

Amongst members of the long stay patient population, there were some who did return home but the process underpinning their release was complex. Discharge usually involved an appearance before the Hospital Management Committee. This process for those who had originally been "certified" was recalled by "B"a male nurse at St Crispin Hospital who began work in the institution in the 1930s:

> *B. "Well I suppose some must have gone home... The situation relating to this, if it was considered by the doctors... I mean, by then of course there were a number of people that... were voluntary patients and that being so, undoubtedly they were going home after giving their three days notice and so on and so on. As far as the certified patients were concerned, it may well have been that some did go home."*

Rights of appeal, before nominally independent bodies did not exist in the modern sense. The issue was decided following referral by the doctor responsible for treatment and then only via the Hospital Management Committee.

> *B. "What happened then, they had to appear before the hospital committee and they decided* whether *or not... alright having been referred to the committee by the doctor, maybe the doctor attended on that occasion to be questioned by the committee, that I'm not too sure about but ... I would have thought that would be the natural sequence of events and whether or not then, the committee decided that... the patient should be discharged well that was it..."*

To be considered for release on the request of the responsible medical officer and then be interviewed by members of the committee must have provided, for those wishing to leave, a powerful incentive to conform. This must have been so at least during the latter part of their stay when any florid symptoms had subsided.

The Mental Treatment Act of 1930 initiated change. Associated with new treatments it gave the right of admission as a "Voluntary Patient". There is narrative evidence

that nurses felt at the time that this was a significant development. As recalled by "B".

> *B. "... this was when the Mental Treatment Act came into being in 1935 (Sic, 1930) and it was considered that if anyone what really... this meant ... that people for the first time ever could volunteer for treatment and furthermore they could discharge themselves by giving three days notice of their intended discharge and that was it but... it followed obviously that anyone that wanted to volunteer for treatment wouldn't necessarily want to go into a lunatic asylum which was basically what Berrywood was, Berrywood County Hospital and.. previous to that it was the County Asylum and so on. So therefore you had to form.. an accommodation for these people to receive some form of treatment if they were going to be encouraged to come into this sort of situation at all. So therefore the Pendereds were built..."*

This act provided the possibility of a relatively short stay as a "Voluntary Patient" for some, without the perceived stigma of "certification". However, Golby (1994:88), notes that with records showing a hospital population at St Crispin of over one thousand, (the hospital was originally constructed for 540 "pauper" beds), there were still only four patients recorded as Voluntary following a visit by the Commissioners in 1932, again re-inforcing the non-consensual nature of the mental health community. The introduction of voluntary patients had the effect of developing another stratum of hierarchy within the patient group and was reflected in accommodation differences as well as legal status. The issue of hierarchy within the patient group will be discussed later in this chapter. In respect of the changes initiated by the introduction of voluntary admissions, Ayres (1976:25) comments:

> "At the time the Commissioners in Lunacy recorded that by 1932 only four patients were resident in the hospital on a voluntary basis, and they hoped that when the provisions of the Act became better known, greater advantage would be taken of it. However, within a year they had hit on a far more likely, and serious reason for the lack of voluntary admissions – that of overcrowding."

(Note: By 1932 the Commissioners in Lunacy had in fact been reconstituted as Commissioners of the Board of Control [Jones, 1972:207]. See page 142.)

Ayres (1976:25) comments further that the numbers in the institution constantly exceeded one thousand and that mattresses had to be laid in the corridors at night. The Commissioners considered

> "...it quite understandable for voluntary patients to find the overcrowded wards and dormitories 'distasteful' and that even if they had agreed to be admitted such patients would no doubt discharge themselves earlier than would be the case in more congenial surroundings."

In attempting to remedy such potential problems and provide a suitable environment for the new group of patients outside the Victorian institution, a new unit was constructed at St Crispin Hospital. A dedicated admission unit for Voluntary Patients, and a convalescent villa, were constructed in the grounds. The new unit, The Pendered Hospital, and the convalescent block were open by 1935.

There may also have been prestige for those staff who cared for the new voluntary group at the Pendered. As remembered by a male nurse "F" who began work at the hospital in the 1950s:

> *F. "Oh yes, yeah, yeah, yeah, yeah, you felt it was more like...you imagined a hospital because you had...it was an admission ward... everything was going on...because at that particular...at that time...patient care was very important ...patient was admitted and he was put straight to bed. He had a bath and then all the physical is done...temperature, blood...blood taken...X Ray, urine tested, everything was done and the patient stayed in bed for three days..."*

This is the recollection of a nurse who began work on the Pendered as a student having arrived from Austria in 1954 and who saw the unit as still having a considerable cachet. This evidence supports an assertion, known to the author, that some Northamptonshire people as late as 1979 still viewed the Pendered as being special, both separate from, and preferable to, the main buildings of the institution. This followed a complaint from some female patients based on the then "Pendered

female" ward, that a letter sent to one of them care of "Pendered West, St Crispin Hospital, was wrongly addressed. They believed the unit was not part of the main institution. There was unhappiness when they found that it was, as the main building was for "bad cases".

A short history of St Crispin contained in a pamphlet printed at the time of the opening of later "Villa" accommodation in 1954 (Northamptonshire Record Office) recalls the opening of this original unit as well as extra staff accommodation:

> "Between the Wars the Pendered, a modern admission unit (1935) for 70 patients and the Nurses Home (1936) with 80 beds, were opened."

This provided scant longer-term relief however because the record goes on to show that by the end of the decade:

> "During the Second World War over 350 patients were received from other Regions causing a considerable amount of overcrowding which has not yet been alleviated." (Archive material - Villa Pamphlet, 1954)

Barham (1992) suggests that the catalyst to the process of change lay in developments in medicine. He refers to a narrowing of the gap between general medicine and psychiatry with the introduction of new treatments from the 1930s. He suggests that this convergence contributed to the changing relationship between mental hospitals and the world outside. These medical innovations coincide with the introduction of the Mental Treatment Act of 1930 (where for the first time individuals could seek voluntary admission specifically for treatment) and may be considered as interlinked.

Although some treatments introduced in that era, such as insulin therapy, are now unused and rejected, Barham (1992:4) identifies that their influence consisted in

inculcating a belief that cures were possible. This belief, he argues, helped in changing patterns of admission and ultimately brought about the relaxing of boundaries between mental health institutions and the wider society.

> "...to a gradual change in the relationship between mental hospital and society, in which the stigma of the asylum was to some degree moderated and the boundary between mental hospital and society became more permeable."

Whilst this may have been the case with the wider society, we have already seen that hospitals had complex and interdependent interactions with neighbouring local populations, and this aspect of permeability applied regardless of medical interventions or changes in legislation.

Role and hierarchy among patients.

Conformity to the rules and activities of the institution were central and behaviour was influenced by other means than physical restraint, including for example through patronage and reward. The place of patients within the institutional structure was not only determined by the nature of their admission i.e. by whether they were voluntary or not. There is also evidence that whether they worked or not was related to accommodation and reward. The nature of patient work activity revealed in the data will be explored later in this chapter. First, on the next page, a map will be utilised in examining the effect that working had on their life and privileges within the institution.

A rough map of St Crispin Hospital in the Northamptonshire Record Office dated 1951 indicates two units within the hospital grounds marked "female working patients" and "male working patients".

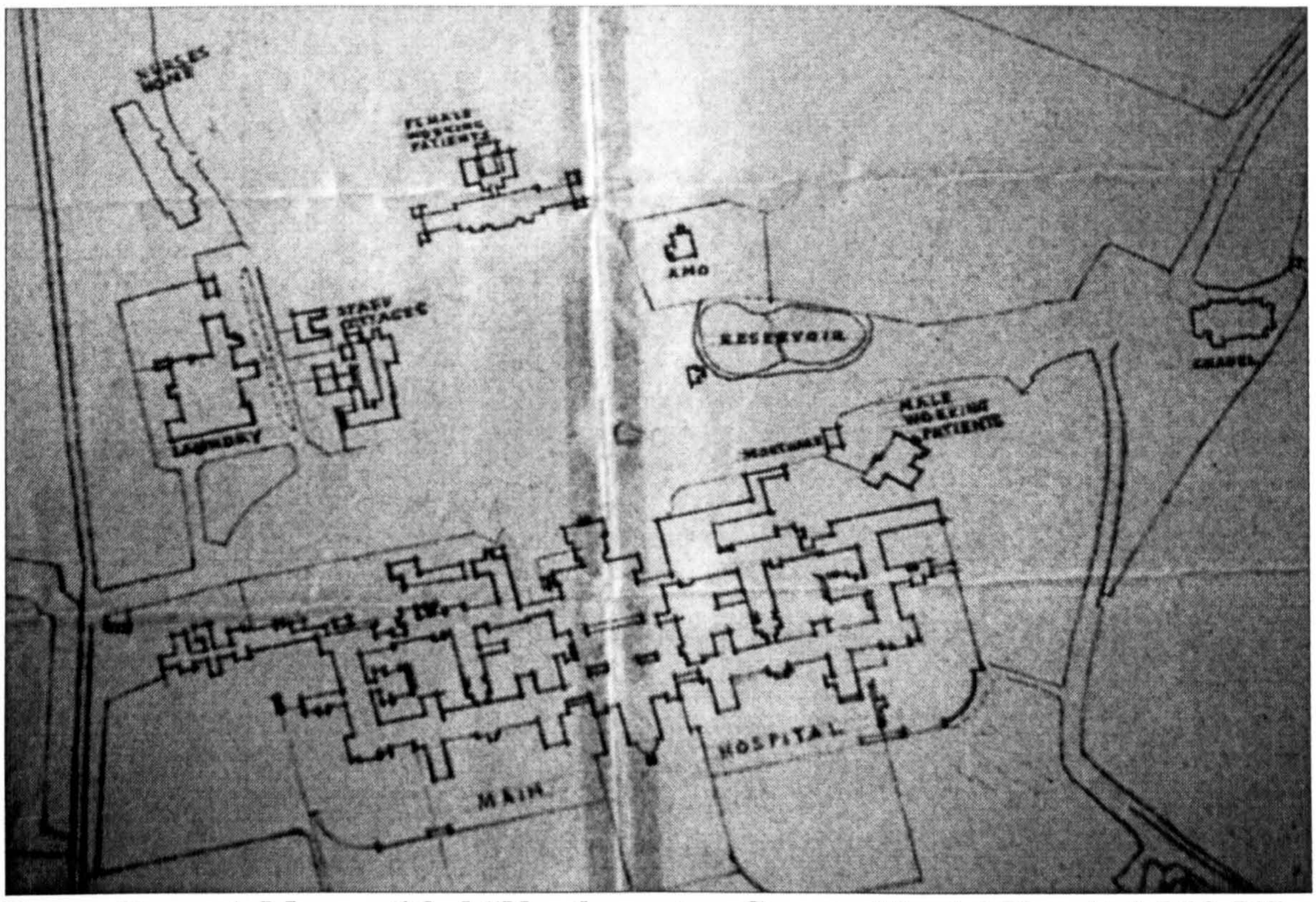


Figure Four: A Map entitled "Northampton County Mental Hospital 5.10.51"

Although falling just outside the period of study in this chapter, the map is close enough in time to indicate a probable continuation of practice. Both female working patients and male working patients are shown as housed outside the main building where the majority of patients would have been resident.

In addition to dedicated accommodation, other rewards might also include special privileges such as permission to stay up later in the evening than other patients. In other words, the special allocation of free time was also included in a system of reward. There is also evidence that tobacco was a currency of reward. As with prisons it was often a currency among patients themselves. This system of reward

and privilege reflected a hierarchy of among patients selected under staff patronage. A male member of the nursing staff "C" employed at St Crispin Hospital during the pre-war period provided narrative evidence that is supportive of this perspective:

> *C. "...one or two patients who always one or two... trusties if you like who were allowed to sit up and they helped around the place in the day time and were well considered...the patients used to get just a packet of tobacco from working down on the farm in those days... their shag as they used to say and the trustie would be given... the charge nurse would always have an extra supply of tobacco that he could give to the people who were prepared to help him around the place... patients and so on...these patients were allowed to sit up until half past nine or 10 o'clock but they were very few indeed just one or two on each of the better of the wards."*

Another male nurse "B" recalled that working was not the only factor when it came to privilege:

> *B. "Oh I think the patients that...the patients that...were co-operative, should I say...and worked ...certainly got...a better deal than those that rebelled or whatever."*

For those who didn't co-operate the same nurse recalled:

> *B. "I think their situation was... one of OK, ...they would get the basics, they would get treated, they would get cared for but they didn't get like the 'extras.'" ...'*

For those patients who worked, the practice of extra reward carried on up until at least the early 1950s when "P" began work at Northampton.

> *"...the patients who worked down the farm got an extra pint of beer a day or an extra.... chunk of cheese or whatever...and I think that carried on ...on...on you know, in a similar manner up t...up to my day."*

The following entry in the minutes of the St Crispin Hospital Management Committee minutes for June 1954 (Northamptonshire Record Office) indicates the extension of a practice accorded towards the men to working female patients:

"RESOLVED
That vouchers or an allowance of money be made to women working patients pro rata to that made to the men patients for tobacco subject to the necessary finances being available. The Committee were unanimous in their Resolution with the exception of one member."

A female patient who had been at Cane Hill Hospital recalls the village-like nature of institutions and the structure of work in this earlier part of the century. Her memory is also of being rewarded in "kind" rather than cash:

P...."Oh, and I used to wash up for a... all sorts of things... but they did reward me, because once a week I was allowed to go to the bakeries... 'cause it was like... Cane Hill, years ago, was like a big, big farm... a big, big village. It had everything, and I used to be able to go to the big... 'cause first of all, Cane Hill caters for 2000 patients... and... there was a bakery department that cooked for staff, and the whole of the hospital... everything... you know, and I used to be able to queue up for my reward and have home made... a piece of what they called home made bread with jam on it, so that was one of the good things..."

"... oh, money didn't come in 'till a lot... a lot, lot later..."

The evidence therefore points to institutions as having strongly hierarchical community structures for both patients and staff that sought conformity within a world of work. To fit within this environment and exist as comfortably as possible required co-operation with the system. In being able to contribute some form of work within the institution, a number of patients were able to obtain special privileges, material rewards in such forms as for example extra food and tobacco and possibly the freedom to receive "passes" permitting outside visits. This, for patients at least, would also be dependent on their attempts at co-operation not being undermined by their psychiatric symptoms.

(3) The Bounded Community?

As we have seen, mental health institutions were strongly internally stratified. Although a large part of the patient population were largely inaccessible to the world outside, there is evidence that the institutions at this period were not as isolated and self-contained as is often portrayed in extant literature. Research data indicates that the segregation of patients was by no means universal and certainly not in the case of the new class of voluntarily admitted individuals.

The popular conceptualisation is of mental hospitals as institutions enclosed behind high walls where relationships with general society did not exist to any depth. Gittins (1998:29), describing Severalls hospital in a chapter entitled "At the Gate" talks of a world of boundaries both within the institution (for which, as we have seen there is some evidence) and with the world outside (for which, this thesis argues, the evidence is much less strong):

> "A gate marks a boundary between two worlds: familiar and strange, outside and inside, seen and unseen, mad and sane."

What has emerged in conducting this research suggests that previous accounts have only looked with what can be termed "long range sight", at a broad, wider geographical society rather than at the relationships that existed between the institutions and their more immediate local society. This was at a time when virtually all industry was localised with most workforces living nearby by virtue of necessity.

This research supports a *new perspective* in which mental hospitals are examined in terms of industry (in the sense of their contribution to local work economies), at the

same time that the delivery of care and containment of the mentally ill becomes commodified. This view will be explored next.

(4) The "Geographic-occupational Community" – "Old Village"

The Internal and External Economies – Working Patients - Self-sufficiency and Industry

The evidence presented in this thesis suggests that the concept of mental hospitals being isolated from the world outside, of hospital and community being posited as opposites is not correct. The evidence for this is borne out in the world of work in particular. Of the individuals interviewed for this research who were ex-members of staff, all lived, during their careers, either within the immediate area of the institution they worked at or, in some cases, for a time, within its walls.

In the case of St Crispin Hospital, within Duston, the local village, the hospital had for many years been a major local employer and could be seen therefore as an important economic power amid the surrounding landscape of village and, originally, mainly farming community. This historic perception of insulated communities with limited interaction with the world outside the gates is not therefore generally supported by accounts gathered for this research. The village of Duston, although ancient, had the asylum built next to it and to some extent from that time they developed together until finally engulfed by the expansion of the town of Northampton and by other industry.

Other institutions had also been built, by design, away from the immediate vicinity of towns and often in association with small rural communities. One interviewee did

not recall St Crispin Hospital staff being located within one particular area of the local village, either the "old village" or the newer built areas later in the century:

"No they were fairly well scattered...fairly well scattered..."

This evidence indicates that there was no closed "enclave" of hospital staff within the village and the area surrounding it but that they were integrated within the local population. This could have been a contributory factor, over the years, in respect of "old village" tolerance towards the patient population. There is oral evidence that the nature of the historic connection with staff, who they knew as neighbours and friends, may have been reflected in this respect among local people as remembered by "J" a member of the medical staff of St Crispin Hospital who began work there in 1956:

> *J. "It's quite clear too that the people in ... Duston had been... much more aware or and in a sense much more tolerant of... the people.. in the hospital than.. those the other side of the town may... have been or might have been simply because of their knowing about it through people who were on the staff..."*

The oral evidence that the nature of the intermeshing relationship between the hospital and the local area also influenced attitudes to patients in respect of acceptance is important. This contrasts with today's "Care in the Community" approach, as discussed earlier in Chapter Three, where the tendency is to see hospital and community as opposites, with "community" as "good" and "hospital" as "bad". Community care does not necessarily mean acceptance by neighbours and the local community of those being supported by mental health services. A male nurse at St Crispin Hospital commented, as noted earlier;

> *C. "... the only people that really had understanding were the Duston people because they... there were patients on parole...some patients had a ground parole and other patients had a two mile parole that allowed them to go into Duston. The Duston people accepted them because they knew them and*

understood...or had a bit more understanding of what was going on in the hospital..."

Of the houses around the hospital site, some were owned by the hospital, including as "tied" houses attached to the hospital farm. As recalled by a St Crispin Hospital farm managers daughter:

I. "...They belonged to the hospital... and they were...there was one specifically for The Wagoner, that was on the farm near The Farm Managers House, my fathers house and for The Cowman of course and The Gardeners cottage was at the top of the garden and then, it was on The Nobottle Road near the Pendered, the cottage that was allotted for The Shepherd..."

The hospital houses described above were mostly "on site". There were others, but few compared to the proportion of "outside" accommodation occupied by staff. This further supports the notion that many members of staff, including Charge Nurses and Sisters, were embedded in the local population.

Local artisans were also participating as employees in the business of the hospital, which was a hive of activity. The business of the institution, as of others, included all of the logistics of maintaining the hospital and those cared for and contained within it, as well as those employed by it. Activities therefore included animal husbandry, the growing of crops, meal preparation, carpentry, and gardening, as well as general labouring.

By the time that engineering, in the form of British Timken, became the largest local employer, roads and transport had developed to the extent that it was no longer necessary for employees to live nearby. Previously, the extent of the presence in the

locality of hospital staff may be gauged by this comment "J", an "outsider" who was employed in the mid 1950s:

> *J. "Well...again by...by the time I arrive things have shifted a bit but it was quite obvious that.. that one had to be very careful what one said to who...whether in or outside the village because they.. they either were brothers or sisters or cousins or (laughs) in-laws. ...*
> *Duston and Berrywood quite clearly had been very much inter-dependent for a long time ..."*

The data reveals that the hospital, associated village and area of housing can be equated to a family-based "occupational community" (Fricke, 1973). The unifying factor was the work of the institution and reflects the words of Fricke (1973:2) in describing seafaring occupational communities earlier in the last century:

> "The ambience of a community, the reality of its existence, may still be seen by its inhabitants as due to a particular occupational activity."

The concept of a work community is a new way of considering the relationships of the old asylums and later mental hospitals with the society around them. Of those ex-staff interviewed for this research, all had lived local to the hospital at the time they worked there. Junior nurses lived on the site, the male members of staff often in single rooms on the wards. A male nurse who followed his father (who did occupy an estate house) into mental nursing remembered that "living in" was compulsory:

> *C. "You had to be.... you had to do three years as a...you had to...even if you got married before your three years was up. You were not allowed to live out and my parents lived on the estate, my father was given an estate house and I lived on the estate but I was required to live in as all the other chaps were that came to work."*

Later in career, "C" bought a house with his wife, also a mental nurse in the local village, Duston.

Gittins (1998:49) in discussing a different institution, Severalls Hospital comments that:

> "Though staff could move in and out in a way that patients could not, such movements were strictly regulated. Entry to Severalls was indeed and entry to another world, another community, but a community governed and guarded by its own laws of gender division, clothing regulations, temporality, hierarchy and secrecy. It was different and special, ultimately, because it was the place of madness, the place where people outside the gates feared to go, both literally and metaphorically. Partly, perhaps, because of that, it was in many ways a *protected* place, both for patients and for staff."

While this view may reflect the popular view of the old mental hospitals already noted, there is evidence that this picture of Severalls is a not a strictly accurate picture with regard to all hospitals. For example, in respect of St Crispin Hospital, there is evidence that far from local residents fearing to go within the gates and into the grounds, some had to be actively kept out. There is oral evidence that staff had to mount patrols to keep local, non-staff individuals, from trespassing in hospital grounds. This is not surprising when the amount of interaction between the hospital and the local community is considered. A member of the nursing staff who began at St Crispin in the 1930s recalled this activity:

> *C. "I used to parade...patrol around the grounds that had a fence all the way round... and we used to... there were gates at the front of the...that were open and you would always have one person round about the gate to stop people, not people leaving at this stage but to stop people coming in, from seeing what was at that time a beautiful, manicured and lovely grounds of the hospital that were kept beautiful by patients..."*

The occupational aspect of mental hospitals in this period applied not only to members of the village populations working within the hospitals but also industry, such as farming.

In Northampton at this time before and during the Second World War, the hospital interacted considerably in a work sense with what at that time was still locally at

least, a prominent agricultural area. As remembered by "I", who was present on the hospital farm at St Crispin during the years of the Second World War:

> *I. "...we had two land girls, that came from away but I don't recall where... and they were billeted... in Duston I believe. I mean ...one of the workers came from Kislingbury ... and of course The Head Gardener and The Wagoner and the Head Cowman all lived on the place...and The Shepherd lived on the place."*

The land girls and other staff mentioned above, who provided a "core" group of staff, played an important role in supervising patient labour. The work for patients, whether on the farm or in other activities within the hospital, was considered therapeutic as well as providing revenue and commodities for the hospital. The Handbook for Mental Nurses (1946:585) in relation to farming and gardening activities states:

> *"Though these have no special relation with shops, they must be noted as forms of industry at once profitable to the institution and helpful to the patient."*

The role of patients in the economy of hospitals and how it is revealed in the data will be explored next.

(5) The enclosed concealed community – work and the long-stay patient core.

A retired head gardener "G" who began work at St Crispin as a dairy boy in 1951 remembers the "gang" system used in employing patient labour on the farm and in the gardens and in particular the arrival of over seventy male patients first thing in the morning:

> *G. "Oh yeah they use...they used to march ...down the farm...down that farm road early in the morning like a battalion of troops coming down there it was (laughs) ...it was...you know that's the best way to describe it..."*

The description by "G" of the patients being marched like troops was not an exaggeration as patients were often moved from place to place in what is sometimes described as a "crocodile". At such times, they would sometimes be supervised by accompanying male staff. Such activity provided the patients participating with meaningful occupation, exercise, fresh air and the privilege of visiting the outer locations of the hospital outside the enclosing wall.

As well as saving on expense to the local rate payers by developing as much self-sufficiency as possible through working farms, other workshop industries such as tailoring, dressmaking, engineering and gardening were also established and involved patient labour. Inactivity and particularly to be "lost" on a long stay ward was considered by patients, as well as staff to be undesirable. A female patient who had been admitted to Cane Hill Hospital remembered:

> *P. "And then... ooh... it started. I was put on a ward with 110 lost patients. Do you know what I mean by lost patients?' ...'You've no idea? Well they were all drugged... drugged up. They looked... they looked in those days, that there was something terribly... they were drugged up, and they just stared at you... and... I was just... well, a maladjusted teenager, you know, full of fun and pranks and everything, and... there I had to scrub wax..."*

Although in different locations, there were often many similarities between mental hospitals. This may have included adherence to a similar architectural plan, except in regard to size. They were also influenced by the same legislative changes and many common practices existed. Among the patient group also, the description of the "lost patient" might be recognised by those with experience of other institutions. To the knowledge of the author, "waxing" and "blocking" was still being carried out in the St Crispin Hospital "Great Hall" in 1970.

The move to some form of work was considered a step forward and, as discussed, provided a route to certain privileges. One man, transferred from Horton Hospital to West Park Hospital in 1939 remembers:

> *O. "....by thirty... by... well... nearly after... forty four... this doctor came up and said, 'Would you like to go over to J Ward', he said, 'and see if you'd like to join the farm party?' You got a farm party going there 'cause, you see, the war, see... forty-four, it was the end of the war. So I said, "Yes, I would, Doctor," so of course I went over there in no time. Next morning, I joined the men who were going out on the truck you know... to Ashley Farm it was... Ashley, yes... and I went out there for the first time... a long field with all one mass of potatoes you know... and we had to keep digging these potatoes up, you know, and putting them in sacks, you know..."*

"O" intimates that he not only worked in his own hospital farm at West Park but worked elsewhere. This was of course during wartime when much effort went into food production:

> *O. "And I started... I got all sorts of... places round there, different hospitals and... and doing things all in farm work, until... and we got to '48, June '48, from '44... [inaudible]... about three and a half years I think I was in the farm party..."*

The contribution from "O" is important because it reveals that in some areas, patient labour was used flexibly, outside the walled institution and on different hospital sites. It implies that any therapeutic benefits that the patient might have obtained (and on one site only) were possibly secondary to the economic requirements of the task.

Other occupational activities were developed within St Crispin hospital in the 1930s, not at that stage by specialised Occupational Therapists but by Nurses. Although given a therapeutic veneer, this industry reflected the Poor Law requirement of

working to pay for accommodation and food. A male nurse who began working at St Crispin Hospital in the 1930s recalled:

> *P. "... there was also Occupational Therapy in its blandest forms...this was done by nurses. I didn't ever see it done but in actual fact.. I understood, one of the earliest forms of Occupational Therapy as such was the making of link wire netting and that was done on a machine. Strands of wire and patients winding handles and... I can't remember where it was done.. But it.. there wasn't a department or anything at that stage then, nothing like that... but the other thing in relation to occupation, you then had to think about what was.. what else was there?"*

The role of many patients in helping maintain the internal economy appears to have been as pronounced at St Crispin Hospital at this time as at West Park Hospital. A male nurse who worked at St Crispin Hospital recalled:

> *B. "There was the farm and the gardens, that was considered to be a form of occupational therapy. That was for the men mostly although during fruit picking time, the women used to be involved as well.... For the women there was the central kitchens and also the laundry, you see, these sort of activities and... don't forget also, the general cleansing of the wards was done by the patients if it... if it was that sort of ward whereby a particular patient...could help in this respect. Don't forget, in those days there were no...ward orderlies. Any of the cleaning was done by the nursing staff, poor old junior nurse again and also the patients themselves."*

This contribution reveals the importance of patient labour in the old institution. Along with the more junior nursing staff, they provided a major resource in providing work. This not only included important aspects such as the supply of food but also activities that were later largely taken over by specialist, domestic, services.

The industrial activities of the hospital, although mainly considered occupational during the early phase of the development of the institutions, were also considered to have a therapeutic role. This has continued into the present with the industrial therapy movement, and is explored further in Chapter Five.

Although the modern concept of patient care rejects any activity that might be considered exploitative, a life of total inactivity for otherwise fully physically fit individuals could also be seen as undesirable. As noted by a male nurse;

> *B. "Well because we were the only ones involved, quite obviously I mean.. we understood that to occupy these people if it was possible to occupy them at all, then quite obviously this was an important aspect of treatment. So therefore, we did our best. Alright I mean we weren't trained Occupational Therapists, I mean, and in those days, there was really no.. no handicrafts as such being done."*

A specialist therapeutic role was later developed by Occupational Therapists within their own department in the 1950s at St Crispin Hospital. This activity continued alongside the use of patient labour on the farm, in the gardens and on the wards however and did not replace it.

Some questioning of the morality of patient labour in the post war period is found in archive material. By 1955, the employment of patient labour was being discussed by medical staff. This was in terms of a requirement that it should be legitimised by them as being therapeutic. This is shown in the minutes of the Medical Advisory Committee for the 25th February, item 34 (Northamptonshire Record Office):

> "Assistance of Patients with Ward orderlies, Groundsmen etc. All members agreed to support individually and collectively the employment of patients in all departments of the hospital provided such employment was therapeutic and helpful to the patients recovery. It was further decided that requests made to the Medical Staff for their selection of suitable patients where help was most needed in hospital departments would be welcomed."

This minute comes at the time of a general move away from the traditional functioning of the institution to a more treatment-orientated approach and therefore a more influential role for doctors junior to the Medical Superintendent. It represents a time when doctors had new tools, particularly drug treatments available. In practice,

patient labour continued to be a contributor to the work of the hospital for some time. In effectively "prescribing" such activity for selected patients, medical staff were in effect legitimising the continuation of the practice. The alternative would have been, however, a boring and unproductive life for many of the patients. The findings of the research reflecting these changes will be explored further in Chapter Five.

The daughter of the farm manager at St Crispin Hospital remembers farming as being carried out on a very proficient basis. The hospital and this part of its industry were in every sense in touch with the mainstream local community and in no sense isolated.

I. *"...they regularly took part in shows and produce from...the farm was exhibited by the National Farmers Union when they had the big County Show and they regularly showed cattle and frequently won prizes...and competitions and things... they joined in nineteen thirty-six I could distinctly recall this although I was very young...the...main Wagoner and his assistant...they each had two shire horses and where the Marina Hospital is now ...I have a photograph of it actually, they...won a competition for ploughing the straightest furrows in Northampton ... That was in ... in nineteen thirty-five..."*

(See photograph on next page)

Figure Five: Ploughing at St Crispin Hospital Farm – 1930s.

At St Crispin Hospital too, the farm provided an important source of supply for the institution and thus kept down any costs that might otherwise have been born by local ratepayers:

> *I. "... meat, eggs, they had free-range poultry. I think they...that and especially in World War Two it was everything came from the farm....especially vegetables like peas and things. They weren't all that keen that they grew so many...so much of the vegetables because they didn't want to spend time preparing them in the kitchens. So I think after World War Two, it dropped considerably, what was required."*

No archive evidence was discovered that the hospital contributed to the dietary needs of the population at large, with surplus food being sold on the open market but staff as well as patients ate within the institution. The farm appears to have operated within the hospital's internal economy selling produce to the institution. As remembered by "I", a daughter of the St Crispin Hospital Farm Manager during the years of the Second World War:

I. ..."Well my father was regularly ...saw the Medical Superintendent. He.. I don't know whether it was once or twice a week he used to have to see a... Mr C..., I think he was ...he'd be something to do with the financial side of the farm because of course he had a lot of bookkeeping to do because... it was in ways the fruit and vegetable everything were sold to the hospital in a way because of that he had to account for that and of course at the end of the year they had to see whether he made a profit or not and I do know that the whole of m...fathers time there he never ran the farm at a loss."

Interview data reveals that profits were reinvested back into the hospital and the farm. An important aspect of this contribution is the perception it gives of the hospital farm being closely linked with the surrounding agricultural community. It gives a strong indication that this aspect of the hospital economy was in no sense isolated from the mainstream. Although there is no evidence of produce being sold on the open market, there must have been other links. These could have included, for example, the purchase of seed and certainly the exchange of expertise at shows and other events. The farm appears to have functioned as part of the local agricultural community, as any other farm, apart from its hospital situation and the source of much of its labour.

"I" remembers a very co-operative relationship with the patients being given a considerable choice by her father, the farm manager in what activities they were involved in:

"Usually my father discussed it with them and if they were particularly interested... say the garden, they worked in the garden. If they were more interested with cattle he... allowed them to work with the cattle and they used to go... sometimes go 'round with the Shepherd or the Wagoner and sometimes come into The Dairy and help clean up."

Patients as well as some from the village might perform duties as general servants for senior members of staff. A house cleaner and others worked for the farm manager and his family:

I. "...yes, for my parents...and then... 'T' who retired after my father,...he worked generally on the farm. His wife used to come every Monday and do the washing for my mother with the old-fashioned copper."

"We had a marvellous patient.... came every day and my father wore leather leggings.... and boots and he cleaned them, cleaned all our shoes and scrubbed the kitchen floor."

The impression given by these data is of a benevolent rural, almost squirearchical environment, with an interdependency of staff, patients and the local community. Absent, however, is possibly the testimony of those that did not, or would not, fit into such a setting.

Within the institution in the view of "I" who was a child at the time, the memory of the 1930s is of pleasant co-existence with no feelings of threat. She stated she has happy memories before she left to train as a teacher:

I. "Well, when they worked on the farm they were exceedingly helpful.. and some of them were allowed to come out...they didn't have a male nurse with them. Some of them were very keen.... just appeared and helped on the farm."

"...and I grew up with mental ... patients around me but they never caused me any trouble...in fact they seemed to be very nice people."

"... it seemed a very amicable, happy place. I had a very happy childhood there... both talking to the patients we never thought of them as...any different from the paid men on the farm".

In addition, "I" recalled she was well known within St Crispin Hospital as were presumably others resident on the site or living locally. "I" was also allowed to visit wards within the main building to collect on flag days for example. Restrictions on her movements around the site were minimal and included trips to the female wards but not the male:

I. "I used to...we had regular flag days to raise money for the troops and things and we used to go and I used to actually go on the wards...female wards... and sell flags."

The fact that a child, or children, were allowed to tour the wards, albeit only the female ones, is an interesting reflection on the nature of what is commonly seen as a closed community that presented a fearful impression to the outside population. Although "I" herself was based on the site and the daughter of a member of staff, she presents a picture of a relatively free environment for herself with much interaction between patients and other, not professionally employed, individuals.

(6) Recruitment and the musical and sporting traditions

A sporting tradition as an influence in recruitment of nurses to mental hospitals is recorded in extant literature. Gittins (1998:173), writing in respect of Severalls hospital, records sport as being "a prime qualification for employment". This was particularly so on the male side of the hospital. A male nurse recruited to St Crispin was not so sure:

> *B. "Well, I mean, if you had any particular skills.. quite obviously, I mean if you were a musician for one thing then quite obviously I mean, you be quite handy in a ward situation particularly if they had a piano and none of the patients were... able to play the piano and so on and so on... it was.. often said that.. you could always get a job at.. Berrywood (old name for St Crispin Hospital) if you could either play cricket or football, you know, and this sort of thing came into it ... I don't really believe that but... certainly these questions were asked, put it like that, whether it had any effect, I don't really know but certainly it didn't... it didn't affect me because I can't stand any ball games, so it didn't affect me."*

However, a possible relationship between the desirability of being big and physically fit and a custodial role is hinted at in the comment of another former male nurse who began his career in the 1930s:

> *C. "...I used to joke that the chief asked me when I first went there...how tall I was and how heavy I was and whether I played football or not but never did ask me whether I could read or write."*

The range of sporting and other activities enjoyed by the staff is shown on front covers of the St Crispin Hospital Social Club Magazine (Archive material - Northamptonshire Record Office). It indicates sections for badminton, bowls, dancing and entertainment, cricket, drama, football, indoor games, tennis, hockey and netball. A nurse who later became very involved in the development of industrial therapy also became a well- known local dance bandleader and provided music for patient and staff functions. Nolan (1993:107) comments on the motivation of men to become mental nurses stemming partially from admiration of the "excellent sporting facilities" at mental hospitals. Although no written policy has been discovered in archive material, anecdotes on recruitment practices such as these can be seen as significant. The acceptance by subjects of these practices suggests they were influential in the formation of the sense of community. A sporting nature and being tall might, hypothetically, have been influential in that a Medical Superintendent and Chief Male Nurse may thereby have considered they were obtaining recruits who potentially could "handle themselves" if necessary.

In addition to sports activities for staff, there were also certainly cricket and possibly football teams in which patients played. One interviewee was not sure about the latter:

> *I. "...used to regularly watch the footballers, my father was ...the chairman of the football club I believe... that was a...in the Pendered field... that was in connection with the hospital"*
> *"I believe it was just staff, there might have been an odd... odd patient ...but I... I can't really recall whether that was the case or not."*

Figure Six: Patient's football team? – 1930s

The inclusion of a St Crispin Hospital male nurse in uniform in the above photograph *may* indicate the presence of patients in the team but not necessarily so. He may, for example, just have been going on or off duty, or have taken time to be included in the photograph as a team member. Sporting activities, as well as being enjoyable were also a useful way in which restless patients could burn off energy. The author knows of groups of patients being referred to a Physical Rehabilitation Unit at St Crispin Hospital, in the 1970s, for games and sometimes relaxation therapy for this reason in particular.

Another important point with respect to sporting and other activities is the amount of interaction engendered with other groups and organisations within local areas, as well as with other hospitals. This was certainly the case with staff sporting activities. With patients, at St Crispin, sporting activities, such as cricket matches with other hospitals, were still taking place in the early 1970s.

(7) Communities within Communities – the gender divide

During the 1930s and indeed right up until the early 1980s in most mental hospitals, there was a segregation of the sexes. Not only were wards segregated but also, it could be argued, virtually separate hospitals for men and women existed on each site. A Doctor who worked at St Crispin recalled:

> *B. "Well caricaturing it ....it was.. the middle of The Concert Hall on a dance evening with men on one side and women on the other.. and they met when ...the music was playing and separated when the music stopped (said with humour in voice)...There was some contact then... I'd understood that the contacts had been rigidly...separation had been rigidly enforced in the past. It wasn't that rigid I felt when I was there but it was ...it was still very much two hospitals..."*

The "men's side" and a "women's side" existed in separate wings, sometimes with separate types of key for each. A nurse who trained at Carlton Hayes recalls:

> *"... female wards and male wards were separated. The hospital had got locked doors and on the corridors, the male side of the building was separated by locked doors from the female side. The only time that you ever mixed really were dances, concerts, church...anything like that..."*
>
> *"...when I say mixed, they all went together but, the male side was one side of the church, the females the other. Cinema was one side male one side female. They mixed at the dance, concerts they were separated."*

The nurse equated the policy to the prevention of sexual liaisons between male and female patients. *"I think it was only for the obvious reason."* It followed a pattern established within workhouses where strict segregation was also enforced, including among families. This policy of segregation is important as it reflects to some degree the continuation of practices from the Victorian age when most institutions had been established. In the period after the Second World War, segregation of the sexes began to be relaxed. One such example was the rigid practice of males and females sitting on separate sides of the hospital chapel. Male and females who were free to leave their wards also began to associate more in the hospital corridors, grounds and

within their places of work. The general policy of unlocking wards contributed to this (narrative evidence from ("F"). Within the wards however, segregation continued. This applied to staff also. There is anecdotal evidence known to the author that there had at one time been a prescribed distance apart that male and female staff had to observe at St Crispin Hospital when walking down the hospital drive. Female staff also had to leave when they married. One of the first nurses who were allowed in 1964-65 to work on a ward containing the opposite sex was male and recounted:

> *"...well you open the doors you think everybody gonna clear off..and actually when it really didn't happen everybody was surprised, the patients didn't run away..you know..even with the integration then, you know, that...female staff were coming over to the male side and male staff was going over to the female side especially on the geriatric side, you know, to help with lifting and that sort of thing..you know..you know, all the staff were a bit ...generally... all the staff you know, were a bit sort of apprehensive about it but..i....its..i....it..went as far as I know..everything went very smooth at that ..at that time".*

These data reveal that gender segregation policies existed at St Crispin Hospital as they also did at Carleton Hayes Hospital. Enforcement of rigid policies of gender segregation in mental hospitals from the nineteenth century until the middle of the twentieth century is consistent with policies in other institutions as noted earlier. Apart from contributing to a policy of making a stay in such a place as uncomfortable as possible, they were also a form of control and particularly so in respect of the control of the sexuality of in-patients and the avoidance of what was considered possible "moral" failings. They reflected also the general regimentation of care in the institutions and the strict governance of all forms of behavior, not just by patients, but by staff as well. This contributes to an assertion that staff as well as patients could suffer the effects of institutionalisation. It has to be remembered that from the founding of the asylums, and into the first half of the twentieth century, this

form of institutional care was considered a solution rather than a negative trait in dealing with those deemed to require it (Jones, 1988).

(8) The recruitment of staff from "outside" communities.

Mental hospitals employed staff initially from many regions and as the last century wore on, from many different countries. This factor influenced the culture of institutions and created a unique community within the local population.

An opinion that mental hospitals deliberately targeted potential recruits in "outside" areas emerged in the pilot study for this project. It was provided by one nurse interviewee in relation to St Crispin Hospital in the earlier part of the Twentieth Century:

> *C. "...the Duston people I understand in my fathers day that they would not employ... local people and that's how my father came to see an advertisement in Suffolk or wherever he was and at that time a lot of the staff, a lot of the charge nurses came down from Durham... when the mines were having difficulties in the early thirties, the late twenties, a lot of people from that part of the world and a lot of people from various other parts of the country, a lot of girls from Ireland of course... and in the very early days it was thought inappropriate to have someone local in case they had a relative who was admitted to the hospital, this was the argument. I am going back now to the twenties and early thirties ... before the days of the voluntary patient..."*

Although such a policy may have been in operation in respect of families of local origin, this did not apply to the families of current staff including the interviewee quoted above, who followed his father into the work, as did others. Another nurse recalled what the experience could be for a stranger coming in:

> *F. "Well a....as a student, the thing is, ...you were the lowest because even nursing assistants because as... as Crispin was at the time...I think everybody it'd be that everybody was related, because they all came from Duston..."*

A policy of only employing non-local labour was likely to have been abandoned by the immediate post war period as demonstrated by the stringent measures taken to recruit.

There is evidence that the problem of labour shortages also applied to hospitals other than St Crispin. In describing recruitment at Severalls Hospital after the Second World War, Gittins (1998:54) talks of an "endemic labour shortage" leading to recruits being obtained from overseas in increasing numbers.

The "Third Open Day" held at St Crispin Hospital in November 1951 is recorded in an archived report (Northamptonshire Record Office). The Medical Superintendent, it is noted, "spoke of continued hardships arising from shortage of staff." In addition, at the 1953 Open Day, "the fifth", a film, entitled "To Heal a Mind" was shown. This silent film, made within St Crispin Hospital by the "Northampton Film Unit", had as its objective the recruitment of nursing staff for the institution. The film was shown not only locally but also widely, on a national basis, being quite celebrated at the time:

> "...in hospitals, exhibitions and elsewhere in various parts of the country. It was also frequently used as a basis for talks on the work of the hospital by members of hospital staff. Such was the film's success that the Northampton Film Unit was awarded the Bryce Walker Cup at the Scottish Film Festival in March 1954 on its account, and in the Amateur Cine-World Competition it gained a Three Star rating."

The film concentrates on a mixture of clinical and social aspects of fictionalised hospital life. The leading actress is seen to join the nursing staff based on a personal interest in psychology reinforced by her incidental involvement in a psychiatric emergency on a railway train.

The film is an idealised portrayal of staff community life. The new recruit sees the woman she initially assisted eventually discharged. The film emphasises what may be seen as other attractive aspects of life in a hospital community some of which were explored earlier, notably sport, dancing and also additionally, romance. It should be judged critically and in context in respect of what it is trying to achieve rather than as an accurate portrayal of hospital life. As noted by Banks (2001:44):

> "Just as all visual forms are embedded in social practice, so too do all visual forms created or researched within the social sciences require an open, broad context reading and a recognition that analytical reading frames are context-specific, limited-use tools."

The fact that these data indicate that the staff shortage was so desperate, allied to the evidence that the film was being shown locally as well as nationally with a local application address at the end, makes it is unlikely that a restrictive recruitment policy was in operation at this later post-war time.

However, until post-war labour shortages, an unwritten policy of local recruitment, or of those from more distant areas may have existed. Such a policy has not been corroborated by archive material. Such a policy would have been significant, as it suggests mutually re-inforcing elements of socialisation and even social control between the institution and the local community in the pre-war period. Its importance would lay in aspects of scrutiny. A largely non-local labour force would possibly have been less influenced and less scrupulous in dealing with individuals known to them. The discovery of such a policy in archive material providing triangulating evidence to support the narrative evidence would have implied deliberate planning on behalf of the hospital authorities to pursue such a course. The evidence that does emerge, however, is of a post-war labour force that, whatever the

origins of some, was based largely in a local setting. This could extend to several generations of a single family finding work within the institution.

What these data do indicate however, is that staff shortages and the desperate need to recruit could be one of the driving forces linked to efforts "open up" psychiatric hospitals to "outside gazes". It can be considered important in understanding the origins of a "community of interest", defined by Willmot (1986:83) as being based on individuals having interests or problems in common. This is a new way of considering the origins of this issue, not previously remarked upon in extant literature. The subject will be discussed further in Chapter Five.

(9) Post-war crisis.

At the end of the Second World War, St Crispin Hospital, in common with other similar institutions, was facing a considerable crisis. The problem was identified by one interviewee, with a medical background, as being related in particular to difficulties experienced by a Medical Superintendent appointed under pressing conditions.

> *"J" "The Superintendent I believe had either moved on or died and he had been ...appointed Superintendent with relatively little experience ...and then the war broke out and the already overcrowded... received another couple of hundred patients ...and the war and all that...with privations and impossible demands ...I think the situation simply got on top of ...him ...others will have talked about the situation during the war but that was my experience hearing about it afterwards that the dear chap was...was overwhelmed ...and ...the situation was really out of hand come nineteen- forty...seven or eight or something like that.."*

The same interviewee also recognised however, the importance of under-resourcing and emphasised the difference made with the establishment of the National Health

Service that was just around the corner in 1948. A nurse working in the same hospital at that time recognised the importance of this change:

> *C. "...it was only when the National Health Service started to finance the service that a little more money became available and of course it was always so fortuitous that the new drugs, new remedies came along in the early 1950s with a little more money, so we were able to start and patients became more accessible.... all sorts of opportunities for recreational, social, occupational activities came along, because patients were as I say, more accessible and needed the opportunities to rehabilitate themselves and lead a much fuller life than they had just sitting around the...sitting around the wards and wandering around the exercise yards... that was another job... was pretty soul destroying... sort of going out in the exercise yards two sessions a day and so on...".*

Other respondents also recognised the changes to hospital communities by the introduction of the National Health Service:

> *B. "Well, I mean, quite obviously it gave the patients a better standard of living for one thing. Don't forget the war was over now, three years over and that meant that the standard of living of everyone was improving.. we had to think about, as I've already mentioned.. shortages of everything but now these were coming more commonplace and furthermore, you see, as time went on, because there was more money available, then quite obviously, wards could be reconditioned, restored and made more acceptable as a place of living rather than an old infirmary an old institution. So all of this was gradually changing and all of this quite obviously had an effect and don't forget also that new buildings, for instance, two new buildings, large brick buildings in the modern form.. Eden Lodge and Grafton Lodge, they were built about that time in the fifties, again of course to accommodate the people who were improving on all of these treatments that were now available to them..."*

The interview data reveals a post-war period and specifically following the founding (and funding) of the National Health Service, of therapeutic optimism not dissimilar to that of the later 1930s. In the case of St Crispin Hospital, a process of reform began against a background of rapid social change. Euphoria in the immediate post-war period, with the expectation of a new world with hope of better social conditions (among other things), combined with a retrospective recoiling, from anything that smacked of enclosed centres of detention. In addition, a number of interviewees

also supported the opinion of "J", a doctor, in identifying what they saw as the importance of inspired and inspiring individuals, nurses as well as doctors, in positions of power, in influencing progressive service development. The data indicates that additional resources were not enough. These issues will be discussed in more depth in Chapter Five

(10) Conclusion.

This chapter has explored data in respect of the historical background of mental health services in the period from the 1930s until approximately 1950. This has included the strongly hierarchical nature of the internal organisation of the mental hospital at this time. The research has also supported a new perspective in which mental hospitals have been examined not simply as bounded communities within a geographical environment. This chapter has advanced the notion of a "geographic-occupational" community to explain the patterns of social life characterising St Crispin Hospital between 1935 and approximately 1950. This community is geographically bounded, although the boundaries are perhaps better conceptualised as being the "old" village within which the institution was situated rather than the walled boundaries of the institution itself. Indeed the location of space in mental health might be conceived as being thought of as a series of permeable concentric locations, with the locked wards a "community within a community", and the hospital but part of a broader village community. The occupational part of the "geographic-occupational" community is arguably what permits the interpenetration of the locations. Ability to perform occupationally as a "trustee" increases the orbit of space the person can occupy. Performance of industrial workshop or horticultural tasks takes one as far as the outer limits of the mental hospital site. In the case of

agricultural labour, this takes one beyond the gates of the institution. The increasing or decreasing ambit for the patient is also a function of the hierarchical nature of this community, with spatial rewards (participation for those who conform in particular ways) and spatial sanctions (the enclosed concealed community with the long-stay patient core). These rewards were granted along with other "extras" such as tobacco granted by the staff.

The results documenting the influence of possession of musical and sporting skills in the recruitment of nurses are generally supportive of existing literature in that these factors were perhaps influential. This chapter also examined the nature of the gender divide within the institutions. Also considered was the possibility of avoidance of recruits from families local to St Crispin Hospital. Although such a policy may have been in operation in this period, it was shown not to apply to the families of more recent staff. A post Second World War crisis that affected St Crispin Hospital and the origins of change with the formation of the National Health Service were considered.

Chapter Five will explore changes that began in the post-war period and in particular from the nineteen-fifties onwards. This will include the beginnings of the move towards community care in the 1960s.

CHAPTER FIVE

VOICES ON MENTAL HEALTH COMMUNITIES 1950 - 1965: The Demise of the "Geographic-occupational Community" and Origins of the "Community of Interest".

Introduction

By the end of The Second World War in 1945, little had changed in the services for mental health with respect to any innovations in practice compared to the pre-war years. In fact, the general stasis through the preceding period of privation had led to much deterioration. During the late 1940s, however, and during the 1950s and 1960s, events and initiatives occurred that sowed the seeds for the service of today. Whether today's service is seen as always better or worse in the eyes of recipients will be considered as will some of the myths that, it will be argued, have grown around the nature of the two seeming alternatives – hospital or community care. Moreover, some of the early initiatives designed to improve the quality of life of hospital patients have been neglected in the literature and will be explored in the data analysed in this chapter.

In 1961, the then Minister of Health, Enoch Powell announced the proposed end of a mental health system based around large institutions. The policy for the future care of the mentally ill was to be community based. In many ways, mental hospitals in the immediate post-war period had become unsustainable. The fabric of the buildings in many of the hospitals was decaying through neglect, while at the same time a total re-build was considered not only financially impossible but also undesirable from a policy point of view.

The general privations of the war years had initiated something of a change in much of public consciousness with a wish to re-build into a society without some of the inequalities of the past. This hope for a better future had to some degree been encouraged by central government as well as personal aspirations. During the darkest period of the Second World War, the population of Britain needed inspiration to fight on. This was exemplified by The Beveridge Report, written in 1943, not at the wars end, and which was the harbinger of the future "welfare state". A Labour Government had subsequently been swept to power in a landslide victory in 1945 amid a wave of optimism. The National Health Service had been founded in 1948. A male nurse who began work initially as an auxiliary at St Crispin Hospital in 1939 and later underwent full nurse training recalled;

> *J. "...one of the great things that happened to St Crispin, as I understand in retrospect, was The Health Service. That here was a hospital that had been grossly deprived, under resourced...for years and at last this became a national responsibility not a local..."*

Suddenly, more money would be available for mental health. (See Appendix Four) This, compared to the past, surprised some older staff including a hospital farm manager whose daughter recalled:

> *I. "Yes, when the National Health Service first came in there seemed to be...endless supply of money. My father was rather puzzled. (laughter)"*

However, on some hospital sites, such as that at Duston in Northampton, some of the old institution buildings are still being used for in-patients even though the main building has been abandoned since the early 1990s. The significance of extra funding at this time, and in particularly in respect of strengthening medical model approaches to care has already been described in Chapter One. These narrative accounts express the views of individuals who had spent the war years and the

period preceding the founding of the National Health Service in circumstances of some privation. Although this evidence is from "J", a doctor and "I" the relative of a member of staff, nurses expressed the same views. As recalled by "B", a nurse at St Crispin Hospital in 1948:

> *B. "Well, I mean, quite obviously it gave the patients a better standard of living for one thing. Don't forget the war was over now, three years over and that meant that the standard of living of everyone was improving.. we had to think about, as I've already mentioned.. shortages of everything but now these were coming more commonplace and furthermore, you see, as time went on, because there was more money available, then quite obviously, wards could be reconditioned, restored and made more acceptable as a place of living rather than an old infirmary, an old institution."*

Another large institution, Rainhill near St Helens, closed only in 1992. However, the problem remained not just of the bricks and mortar but also of the social structure of the old hospitals. A long process of change lay ahead.

The data revealing themes of this period from 1950 to 1965 will be presented in the following order:

(1) Community and control – medical or penal, uniforms and identity.

(2) The unsustainable community of the immediate post-war period.

(3) The "Geographic-occupational Community" – post-war survival

(4) "New village" and the beginning of the breakdown of the "Geographic-occupational Community".

(5) The role of powerful and/or charismatic individuals in the initiation of change.

(6) Insiders looking out; outsiders looking in; and the origins of "Communities of Interest".

(7) Multi-regional, multi-ethnic, multi-cultural hospital communities.

(8) The beginnings of patient choice and educational initiatives in the wider community.

(9) New approaches – physical therapies.

(10) New approaches – "therapeutic communities".

(11) Rehabilitation and the re-emergence of the individual.

(12) Conclusion.

(1) Community and control – medical or penal, uniforms and identity.

Following the Second World War, the nurse's uniform policy remained in place in mental health. Its demise has subsequently been protracted. Any changes were purely in terms of fashion and in fact, some hospitals still retain uniforms in certain areas of work. This includes the private St Andrew's Hospital in Northampton and the elderly in-patient services in many National Health Service Units. In the 1950s and 1960s females in most areas continued to dress in much the same way as their counterparts in general nursing.

The image portrayed by appearance could be important in establishing the nature of a community, as discussed in Chapter Four. Uniform could portray a "medical" image in females and an authoritarian image in both but particularly among male staff. Male nursing staff, except in "special" hospitals where there was a tendency to retain prison officer-type uniform longer, were issued with suits in the later post-war period. An ex-male nurse at St Crispin Hospital recalled:

> *B. "But then of course don't forget that in the fifties and then we had the Mental Health Act came into being... 1948 and then thereafter, you know...well it was then considered, right well, these sort of uniforms were really a bit... a bit.. ancient and... we should start thinking about putting male*

nurses in... lounge suits and so on and so on and this, I suppose it must have helped. Whether it did or not I don't really know because you still have to think about... how the reaction between male staff and patients..."

At St Crispin Hospital, male staff were provided with lounge suits made by the hospital tailor in an attempt to change their image. Many female staff were reluctant to part with uniform and in many institutions this remained so up until their closure. As recalled by an ex-female nurse who worked in a Leicester hospital:

D. "I don't agree with it in certain areas. I think I... I never, I never ever took patients out into the community wearing a uniform because I think it draws attention to them... and all the other things that go with it, but I think on the ward and in the hospital, the patients look for the uniform, relatives look for the uniform and I think with uniforms going the respect has gone on every level. Patients don't respect staff any more. Different levels of staff don't respect their seniors. Relatives don't know who the staff are. Patients don't know who the staff are at times and I think.. it was a retrograde step."

To some, an institution retained a formal and almost military atmosphere well into the 1950s and beyond. This was particularly so on the "male side" of St Crispin Hospital. A doctor recalled:

J. "Well yes...I remember there was a general feeling ...of discipline particularly perhaps on the male side where the...there was a... tendency for...I mentioned one chap who was a Nursing Assistant who...stood to attention at the side of the corridor when I passed (laughing) you know and ...it was that sort of thing ... I ...I was appalled (laughing)..."

The doctor, who recalled this tendency, had been an officer in the army during the recent war. The man who stood to attention had also possibly been a member of the armed forces at the same time. Where at one time a senior doctor might have favoured such behaviour, this doctor had different social attitudes and at one time had enquired about the possibility of joining the hospital officer's branch of the Confederation of Health Service Employees (Archive material). Other members of

staff who had experienced war time service might have been less likely, now they were demobbed, to accept strict hierarchy and deferential attitudes.

These data help demonstrate the tension that had begun to develop between traditional aspects of institutional life and an impetus to change in the immediate post-war period. Also shown is the fact that it was not change by easy consensus. Some staff were reluctant to let go of what they saw as positive aspects, such as uniform for female staff as noted. This contrasts with the attitude of "B" who had enviously seen female staff as looking like "nurses" while he looked like a figure of fierce authority in his "prison officer" type uniform. Alongside changes to factors that had underlined and sustained authority and hierarchy, such as uniform, that had become more untenable in the newer freer social outlook of the 1950s and 1960s, other changes were also taking place.

(2) The unsustainable community of the immediate post-war period.

In the immediate post-war period, the stagnation of the general infrastructure appears to have been considerable at St Crispin Hospital in Northampton. A member of the medical staff remembered:

> *J. "Well, when I arrived the place had ...still got twelve hundred patients. That was the beginning of 1956. It had had over fourteen hundred probably a year or two earlier...The place was grossly overcrowded, obviously it was understaffed. It was grossly under-resourced..."*

The problem of poor staffing levels was one that appears to have been ever-present, certainly at St Crispin Hospital and efforts to alleviate this have been referred to in Chapter Four. The general physical living conditions at St Crispin were very bad also and crushed any attempt to retain individuality for long stay in-patients. As recalled by a doctor:

"The dormitories were bed to bed. There was no room for a bedside locker in the place. There were no curtains on the windows. The... the boilers were ...what's the word I want...quite...quite insufficient they'd been running down..I gather that the insurance people had ...had progressively lowered the permitted boiler pressure because they being old and so on and that meant the laundry worked more slowly and the central heating worked ..didn't work properly...and there was a...on a really cold night there was ice on the blankets in the ...in the dormitories..It..this was when I arrived and things had obviously been much worse before..so that ..the whole place had ...really...got to the state where things were ...were pretty awful."

It was therefore not only attitudes and practices that had remained largely unchanged. Money that would have enabled a replacement of failing facilities and physical structure had not been forthcoming. This along with staff shortages and management problems associated with a previous Medical Superintendent during the war years had created a crisis of morale. The philosophy and operation as well as the fabric of what still was the Victorian Hospital had reached a point where it was no longer tenable without change. It will be argued later in this chapter that efforts to alleviate staff shortages and improve physical conditions led to new ideas being attempted, thus creating a catalyst for change. This included the inviting of volunteers into the hospital community and subjecting it to outside scrutiny. Other changes in the relationships that constituted the Geographic-Occupational Community were developing slowly and unevenly and will be explored next.

(3) The "Geographic-occupational Community" – post-war survival

The relationship between the hospital and the local community of which it had been very much a part in pre-war days was, therefore, slowly beginning to change. This happened with greater speed in some areas than others. One subject "K", born in 1952, spent her childhood in proximity to Rainhill Hospital. "K" could remember, of

her childhood, things that indicate Rainhill retained something of an "old village" culture, the culture of the "occupational community".

> *K. "Well... my ...uncle ...worked at Rainhill... there seemed to be quite a bit of contact between the community and the hospital ..although at that time, I mean it was....it had the feeling of quite a closed community in the sense that it was behind very, very high walls...I think they even had glass you know on the top and....huge..it was on both sides of a main road ...if you've ever been up to Rainhill Hospital it's a huge site and there's a road sort of snakes through it ...so... but there was... quite a bit of contact in that people did...come out but....you know, it was like...people were allowed out for... certain parts of... the day so they would, you know, certain categories of... 'inmates'...I use that term because I think that's how...how they were seen actually. ...Certain patients were allowed out... so there was some kind of mixing."*

An ex-patient who originated from the St Helen's area recalls the nature of the community at that time:

> *S. "My mum actually still lives in the house where I grew up and where she herself was born. It's in Parr which is one of the original villages that formed St. Helen's. It was a, very much a mining and gasworkers' community, very working class. A very close community, in those days, but it's changed considerably now."*

Admitted under a Section of the 1959 Mental Health Act in 1968 "S" recalls Rainhill Hospital as offering an active environment:

> *"Oh yes, yes, there were, there were, there was some sort of sports, sports hall actually available in the hospital but the thing that I got the most out of, therapeutically really, was, there was a centre that was called the Community Therapy Centre and this was aimed at younger people who were stuck in the hospital for lengthy periods of time, often perhaps the more intelligent people who, who were able to get their mind around the activities that were, were on offer and we used to, we used to do sports, we'd play in the, in the sports hall, we'd play volley ball and badminton."*

The more traditional inter-hospital sporting activities that had largely died out by the 1980s, if not before, were still very much part of community life at that time. In a further comment "S" remembered:

"We would also, sometimes, visit other hospitals, there used to be a sort of a, a mental hospital league and we'd, they'd take us in a coach and we'd visit other hospitals and in winter we'd play netball, in summer we'd play rounders, the men would play football and cricket, that could be enjoyable."

For this individual, the activities provided an approximation of some home based activities. However, in one piece of dialogue, an ex-patient "T" remembers that although he was very keen on sport, he was excluded in one hospital:

"In summer, no I didn't play, I watched it. I used to go down to the field in Napsbury, they had a great big field, cricket field. I used to go down Saturday afternoon and Sunday afternoon and watch cricket and I was dying to play."
"Who, who would be playing?"
"Napsbury cricket team, Napsbury cricket team,"
"Would that ?"
"They used to have a cricket team."
"Right, was that patients?"
"Staff, not the patients, staff, yeah."
"And they would be playing against other hospitals?"
"That's right, yeah, against Shenley, and against different hospitals around."
"But no patients?"
"No patients, no, no."

Many occupational regimes were developed in the newly emerging "Day Hospitals" that developed in the late 1950s and 1960s. These new services, such as "The Mayfair" in Kettering and "The Redcliffe" in Wellingborough, were often based in towns away from old institution buildings. They went on to provide the core of new community resource centres where community psychiatric nurses and occupational therapists as well as medical staff would be based in the newly emerging services for today. An ex-patient remembered:

"Also in the Community Therapy Centre where you, you'd spend most of your day, there would be quizzes, there were books available to read, discussions, board games, cards, all sorts of activities really and that, that was, that was a positive thing to offer people because it meant that, even though you were feeling ill, you had something, something approximating to what you might be doing if you were at home and leading a, a more normal lifestyle, and that, that was, that was a really good enterprise. I'm not sure how long that actually lasted in retrospect but it was there for quite some years and people got a lot out of it."

Although such services improved the quality of care for many, particularly those who would experience short admissions, a large core of long-stay patients remained in most institutions. However, these services that developed alongside the old hospitals were partly initiating the structures of the services that would come to replace them. For the time being, however, the hospitals remained the centre of the treatment and residential networks that constituted the service. They were controlled by doctors who still utilised beds much as a physician would in a general hospital. At St Crispin Hospital, however, with social, attitudinal, transport and demographic changes, the old, sustaining community was beginning to break down. This will be examined in more depth next.

(4) "New village" and the beginning of the breakdown of the "Geographic-occupational Community".

There is oral evidence, as noted earlier, that the local community around Rainhill in this period, the 1960s, retained the more "accepting" views of the "Geographic-Occupational Community". At the same time, the beginning of change began to show, with increased freedom for the residents:

> *K. "Little...little groups, yes but certainly I can remember individuals being... I mean coming into the pub so they certainly didn't seen to be supervised ...directly..."*
>
> *"...I don't get the feeling of any hostility at all towards...towards the community there... as I say, we pe... some of them come into the pub. I can remember one old chap, he used to come in...very regularly and I think my Dad used to ...you know, slip him the odd drink when he didn't have money and things like that (laughter) he used to...he used to bless everything before he came in he obviously had some sort of religious... delusion or whatever 'cause before he came into the door he'd do... the sign of the cross and then before he sat down he do... and this was just sort of taken, 'well here he is again', it wasn't a kind of 'Oh we must avoid this person', it was ...he was just accepted as, you know, just as part of the clientele, you know...slightly odd 'well he's a patient, what do you expect?' you know...yeah very tolerant actuall...generally speaking."*

"...if you'd see someone sort of behaving slightly oddly in the street it would be 'Oh it's a patient' and you know, we wouldn't worry about it, it's just a patient...whereas if in another community that sort of behaviour, people would be...concerned... and I guess intervening and or frightened or whatever, but for us it was well 'it's a patient'. So if you saw someone talking to themselves for example, you know, you wouldn't be alarmed by that. It ..it would be just a part of normal, well 'it's a patient".

The same liberality and familiarity within an occupational community was also recalled as having existed at Duston, the village local to St Crispin Hospital. This was discussed in Chapter Four. It was remembered nostalgically when compared with the experience of the "new village" as the town expanded and the old community changed along with a decline in the traditional tolerance of mental patients. A nurse who worked in St Crispin at this time and eventually became Chief Male Nurse recalled:

C. "The 'old village' just would take no notice of them. I mean, there were a lot of the patients used to go in the local pub and have a drink and they sat down alongside the other villagers and were accepted."

Prior to the building of St Crispin and for a considerable time after, the main local industry had been stone quarrying and iron ore extraction. Golby (1991) describes the great changes that had taken place to Duston, since 1845, thirty years before the original asylum was built there:

"Duston, with its current population of 20,000 is now part of the vast expansion of Northampton, yet in 1845, at the southern end of the parish, Old Duston village consisted of only 145 dwellings. These dwellings were mostly tied cottages, being part of the estate of some 1,760 acres which was owned for 250 years by the Melbourne family of Derbyshire. At the same time, New Duston was a tiny hamlet at the northern end of the parish, where most of the men worked extracting the famous 'Ryland Stone' from stone pits in the Port Road area."

Into this area came first the industry of the new asylum and much later the roller-bearing factory of British Timken. Golby (1991), who has written separate work on

the history of St Crispin, fails to acknowledge the potential impact upon employment of the new hospital. With a requirement for staff of all kinds, not just nurses and the few doctors, the new institution must have become a major local employer situated as it was on the rural outskirts of the town of Northampton. In addition, transport at that time was horse-drawn and the workers in local industries tended to live in the localities of their place of employment. Unfortunately, no archive material was discovered that gave any indication of the percentage of local employees. After these developments took place, the village was swallowed in the general encroachment of housing with town expansion. However, this effect happened much later than in the case of the other Northampton mental hospital St Andrew's.

Sometimes problems with a new group of residents could provide particular difficulties with uncomfortable echoes today, as the nature of the old "geographic-occupational community" broke down:

> *C. "Well, when the new estate was built down 'S' Road there...that bordered the hospital estate and I remember one day as chief male nurse being asked to go down because someone was complaining that a patient had given their daughter sixpence or something and they saw some ulterior motive in this... and there was a group of people waiting there saying that it's not fair that this person should be allowed to walk around...and I knew this patient extremely well and he would never ever be... abuse anyone at all. Even people in...friends in the hospital or outside...and I explained to them...and they had only just moved in. They were not people of Duston and their houses were as I say...right on the boundary of the estate... their back gardens as you know ran right up to the road where the Princess Marina is now and that was a good example of people's fear of the hospital and the residents of the hospital."*

This incident can be interpreted as revealing a new sense of perceived risk associated with mental health service users among the new, incoming, population of Duston. This is revealed in the data as corresponding to different attitudes among

some of this group in comparison to the old, "people of Duston", referred to above. Another member of staff also saw the changes taking place as the relationship between the institution and the makeup of the local population gradually changed:

> *"...and Duston was beginning to grow and St Crispin was...had become St Crispin instead of Berrywood and ...all the other changes were beginning to happen so the relationship between the hospital and... and the...village...village ...was changing."*

Unlike at Northampton, "K" could not recall attitudes changing at Rainhill as time passed. However, change would self-evidently have occurred to different degrees, at different speeds and to differing extents in each area. In some, the encroachment of new housing can be said to have made a difference, in others there may have been little change in the composition of populations at this time.

As in Northampton and other areas, the local population at Rainhill was still very much involved in the industrial nature of the institution that was at the heart of the local "geographic-occupational community" at this time, the 1950s and 1960s:

> *K. "... I mean obviously there must have been a lot of people who worked up there ...in other capacities. I mean there must have been a whole army of... I mean because it was such a huge place, there must have been a whole army of... cleaners and...and whatever from the local community... working up there...It was known...it was actually known colloquially as 'the building'."*

The interdependence between local people and the hospital at Rainhill also continued into the 1960s.

> *K. "I can't quite... remember when it all kind of opened up but...obviously it became a much ..it became much more common I think for people to..to move in and out...later on but there were people who came out and worked in the community because we had...we had someone working for my dad so... (laughs)...This guy worked.... just casually for my Dad. He would tidy the garden. We had a bowling green at the back of the pub and he'd do some jobs on that or he'd shift crates in the cellar and (R. Sort of 'pot..pot man'?...and collect empties and...Yeah tha...that sort of thing..."*

As the locally based occupational communities began to break down, new relationships started to be established with new influences that moulded the progress of the services for mental health. This process and how it began to evolve will be explored later in this chapter.

In respect of direct access by the general population to Rainhill Hospital grounds in the 1950s "K" recalls little taking place in contrast to the oral evidence in respect of St Crispin Hospital that suggested extensive contact, albeit at a much earlier date:

> *K. "...very little access. I went a few times with my uncle I can remember as a small child. He used to take me because they...they did use to have...I think they had some sort of 'open days' because I think he took me along and I know there were cricket matches and I'm not quite sure whether they were between the staff and the patients or whether they were between...the community and the...and the...and the ...patients and staff..."*

The fact that there appeared to be less access at Rainhill than at St Crispin hints that this hospital may in some ways have been less embedded in the established local community than the Northampton hospital. However, the pattern of other activities such as the "open days and cricket matches referred to above indicate that many of the other activities appear to be similar.

Exploring the experience at Rainhill Hospital in juxtaposition to St Crispin Hospital has already been considered from a methodological point of view in Chapter Three. As noted, there are obvious differences from the point of view of hospital size, the size and type of population served and the histories of city and town. In respect of their both being, it is argued, part of geographic-occupational communities, however, there would also be factors in common where triangulation could be

sought. Both communities seem certainly to have suffered the same ultimate fate, subject to similar forces, albeit at different rates.

(5) The role of powerful and/or charismatic individuals in the initiation of change.

Changes to the institutional system in the post-war period and the initiation of those changes will be explored in this section. A strong theme emerging from the transcripts of interviews related to the significance of sometimes powerful but charismatic individuals in the initiation of change. These may have been from either nursing or medical backgrounds. For example, Nolan (1998:15) describes the influence of nurses at the Retreat at York after the Second World War, "when psychiatric nurses returning from service in the armed forces sought to transfer the philosophy and practice of battlefield nursing into civilian work." At St Crispin Hospital, the evidence points to a number of individuals from a number of professions to have co-operatively created a catalyst for change.

In the immediate post-war period, a new Medical Superintendent began work at St Crispin Hospital. The hospital had been adversely affected by the privations of the war years and was in a bad state of neglect, as already noted. This remained the case even after the founding of the National Health Service in 1948 and well into the 1950s.

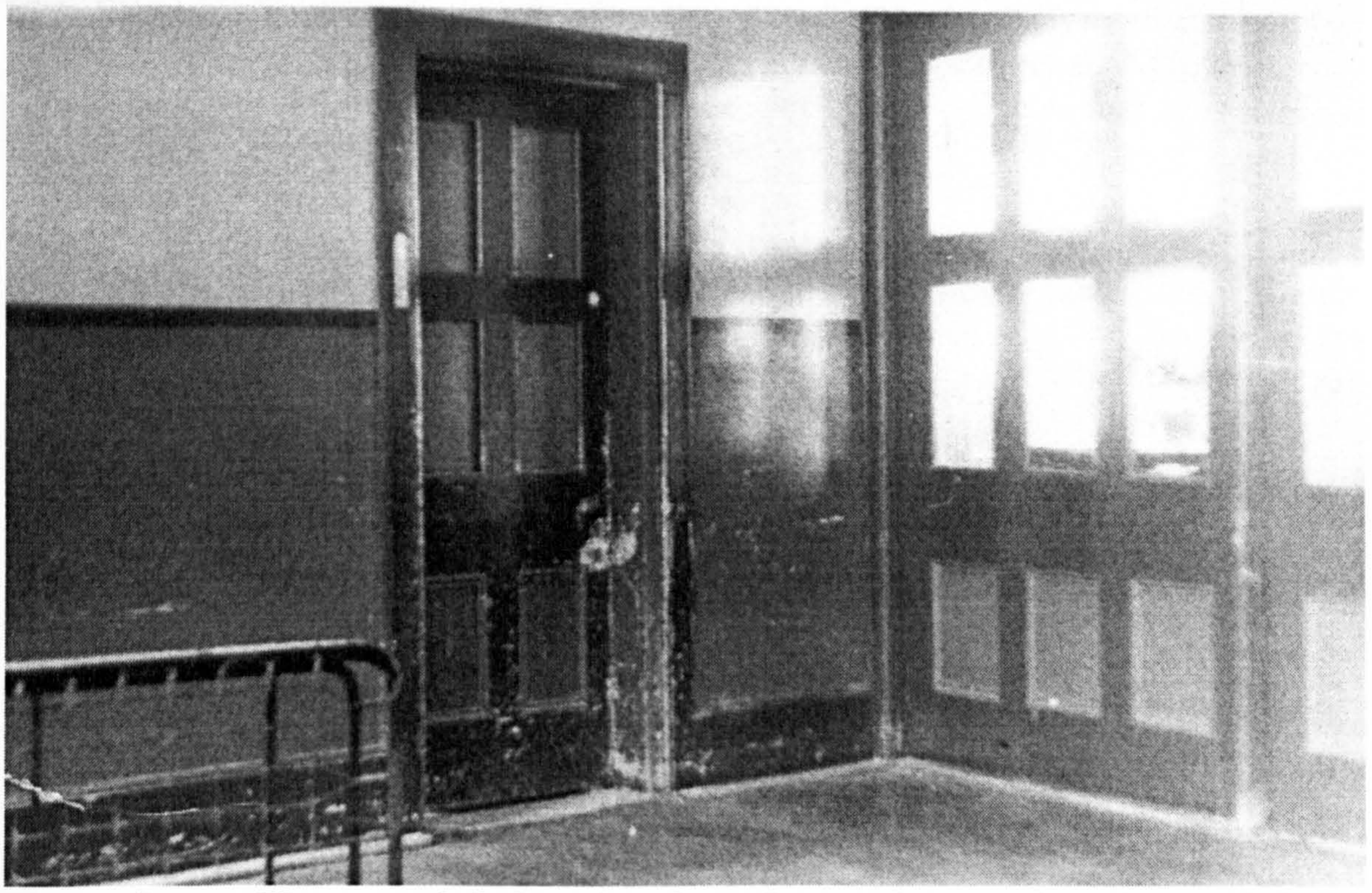


Figure Seven: Photograph believed to have been taken to show internal decay at St Crispin Hospital – 1940s?

In the view of "J", as already noted, decay was not only related to bricks and mortar. A member of the medical staff, he began at work at St Crispin Hospital in 1956. "J" felt that much stagnation in the hospital stemmed from poor morale within all layers of staff, partly reflecting the appalling working conditions. This had affected most, from a previously acting Medical Superintendent down.

The acting superintendent left and was replaced, but the implementation of change was difficult largely because of the continuation of the cycle of overcrowding and understaffing allied to strongly established practice. It has been acknowledged that staff as well as patients can suffer from institutionalisation:

> *"I think that was...it was mainly a hangover...or of partly continuing the impossible business of overcrowding and understaffing...on the one hand and of the continued influence of members of staff who'd been there a long time who had in a sense survived only by...minding... people in ...as a crowd*

because that's what they had been as it were...and not being....able to sort of give consideration to individuals as individuals ... simply because they were swamped with numbers..."
"...many of them had been there for ...for decades...worked through thick and thin and had developed a system of coping...and I didn't feel that this was in any way.. malevolent or deliberate but simply a sort of ...'modus vivendi' if you like..."

This contribution reflects the difficulty experienced in "turning round" such a well-established and massive organisation with an "old" culture and mode of practice much of which must have been based on tradition. A notion of many staff performing a largely custodial role is reflected in the next contribution.

A volunteer "L" who began her association with St Crispin Hospital in the early 1950s recalled her early impressions first of some of the in-patients but also staff:

"...their behaviour was so ...extreme that ... you had to have a special way relating to them and there had to be discipline and...I don't think in those days that many people had much hope of improving things, they just ...I mean I don't think even the nurses ...earlier on ...the other old ones saw themselves so much as nurses as warders ...who just helped make people safe, comfortable...fed ...I don't think they saw themselves as having a possibility of ...of getting them back to anything like normality ..."

The data suggest that in order to initiate major change, the efforts of a few key charismatic, albeit authoritative, figures was instrumental to the success of such initiatives at this time. Such authority was forthcoming, in the case of St Crispin Hospital from, in particular, a respected, reforming Medical Superintendent, his successor, the first Medical Director and a reforming and influential Chief Male Nurse who eventually, following the early death of the last Matron, became Head of Nursing. These individuals are seen as giving authority to significant others including nurses and doctors in the initiation of change.

B. (The Medical Superintendent) "Yes...I thought sort of you, know here was a person.. who obviously cared and ...people treated him...with...with respect but not ...not obsequency."

It is also worth remembering that without support from many of the nursing staff and others such as newly emerging Occupational Therapists, the Medical Superintendent Matron and Chief Male Nurse would have had difficulty, if not found it impossible, to initiate changes such as the introduction of non-professionals into contact with the patients. Regime change in senior nursing positions was also seen as significant among early volunteers. A volunteer "F" remembered reactions to volunteer based initiatives:

> *L. "I mean the...the senior staff, were very good ...and ...when I first went there was a ...what do they call the Chief Mental Nurse?...Chief Male Nurse, yes ...the Chief Male Nurse...had been there donkeys years and was on the point of retirement ...and...I don't think that he particularly ...thought it was a good idea ...but then ...when Mr X came, we did."*

Thus, it may be argued that the importance of enlightened reforming powerful individuals (or the lack of them) on the fortunes of the residents of an institution, was crucial in determining the nature of a specialised community.

In view of the power wielded by medical superintendents and senior nursing staff, as revealed in the research data, their influence on operational matters was very powerful. The problems experienced in St Crispin Hospital during the years of the Second World War, were attributed in the narrative and archival evidence to financial shortfalls within a decaying building and to the Medical Superintendent of the time being somewhat "overwhelmed" by the situation. When a new superintendent replaced a "stopgap" appointment, his power must have been very influential in what happened next. The narrative evidence is that the individual who took over, along with, in particular, the far sighted Chief Male Nurse drove a series of progressive reforms which carried and inspired other staff within the institution.

The evidence is of individuals who would rightly be described as progressive and charismatic. This explains an apparent contradiction in that, in a deferential culture, a powerful individual who is charismatic can, if he (or she) wishes use the influence and power they have to change that culture. There is archive (mainly letters to a local newspaper) evidence that some individuals did resist reform.

This mood was caught by volunteers such as "L" who wished to contribute public service. The options for individuals rooted in the past and happy with traditional approaches, would have been to resist change, a losing strategy long term. This is not to say that the charismatic individuals mentioned above would have wished to do so. Rather they appear to have caught the mood of the time. Some of the changes initiated and/or supported by these individuals and others, and the effect they had are discussed in the section that follows. .

(6) Insiders looking out – outsiders looking in and the origins of "Communities of Interest".

The role of powerful individuals in respect of the "opening up" of services to a broader community gaze, in attempting to induce change, will be first explored in terms of the beginning of voluntary in-hospital services. This is a neglected area in terms of extant literature on accounts of hospital-based changes in mental health services in this period. The early history of hospital-based voluntary services and interest groups in mental health is important in understanding the origin of what will be termed in this research project "Communities of Interest". It will be argued that this theoretical conceptualisation best reflects the current mix of voluntary services alongside statutory services and is found in little of the literature dealing with mental

health. In view of the widespread growth of voluntary services generally, and the crucial role they played in the closing of the institutions and of advocacy in mental health services today, this is a serious omission. In considering neglect of the history of specific voluntary services within hospitals, it is recognised that specific interest groups such as "MIND" have long and distinguished histories and are also part of the development of "Communities of Interest". A characteristic of a modern mental health organisation such as MIND is that it is also a service provider alongside the statutory services.

MIND was originally called the National Association for Mental Health and was inaugurated with the amalgamation of three other mental health organisations in 1946, thus predating the establishment of the National Health Service by two years. The organisation, which users of the service can join as members, has a strong ethic towards the empowerment of the mentally ill. All voluntary organisations complement each other and provide alternatives in areas where particular groups may be weaker. An ex-patient commented;

> *S. "Yeah, I am a member of MIND, you know, locally. But, you know, there's, there's nothing sort of locally available as regards help. No, I would normally phone the Samaritans. I mean sometimes what a Samaritan will say 'oh dear' you know 'would it not be better if you contacted your doctor [laughs] what-have-you' and I say 'No, no thank you'. No it's just, I think it's probably hard for people to understand, but it's sometimes experiences do things to you that change your attitudes and ideas and at this, this point in my life I don't feel that mental health services have got anything positive to offer me. So even though, at times, I do sail close to the wind, I prefer to deal with it myself and I know I'm not the only person, with my experiences, with those feelings. Yeah we, I think we probably feel let down by society and if the hallmark of a caring society is how it cheats it's sick and vulnerable members, well, our society's letting the mentally ill down. That's, I, I do feel that, but I don't feel sorry for myself, I just get on with it mostly."*

The groups challenge thinking on mental health issues in many ways. One article, originally printed in "Open Mind" in 1998 argues for "a survivor controlled museum of madness." Beresford (1998) states:

> "If mental health service users/survivors are to take charge of our future, then we must also regain control of our past. That past, at both individual and collective levels, has been largely appropriated, denied, controlled and reinterpreted by other powerful interests, notably medical professionals, the state, politicians, charitable organisations and the media."

The silencing of the voices of the mentally ill by vested interests, powerful voices and bureaucratic systems has been discussed in Chapter Three. Beresford asks when the "last of the thousands who spent decades in them are dead", who will know what life was like for them. This is one of the reasons why oral history is so important is that it provides a means of recording the views of the less powerful. It is also the reason that the author attempted (unsuccessfully or with limited success) several strategies to uncover not only voices of the mentally ill from national sources (such as the National Sound Archive) but also from the potential local community who may have spent time in the Northampton-based hospitals. It is also the reason that opportunities for obtaining such an interview were deliberately kept open until the final days before submission of the thesis.

The fact that change appears to have been driven by powerful and charismatic individuals, itself suggests the considerable disempowerment of the patients. This seems to confirm the Foucauldian view that whilst power is always potentially dangerous, this does not necessarily imply that the power does not produce positive effects. For these new effects might include a new system of patient governance that many preferred to previous modes of control. Feasible alternatives to such patriarchal reform had not yet been developed, although that was itself about to

gradually change with the development of advocacy and other empowering initiatives by MIND and others. Among other non-statutory organisations operating alongside MIND at the present are The National Schizophrenia Fellowship, The Manic Depression Fellowship and the Mental After Care Association.

One other factor that was certainly important was that the self-contained nature of institutions that was once beneficial in terms of the focussing of resources such as food production and staffing was no longer effective in terms of economy of scale. For example, with the improvement of transport, staff no longer had to live within the shadow of the institution, although many students continued to "live in" for convenience. The development of the mass production of cars also favoured more car ownership and ultimately "outreach" work by staff. Communication among service providers was made simple by the expanding use of the telephone. Problems of communication were no longer solved simply by being based on a geographically compact site. The original relative self-sufficiency of the institution was no longer a powerful factor. This was certainly so after the founding of the National Health Service made money from central government available. The produce of St Crispin Hospital farm was no longer favoured when it could be bought-in and used, in line with preferred practices. As remembered by "I" who was the farm manager's daughter;

> *"Well after World War Two, they decided that they didn't want so much work like for instance preparing vegetables... they would rather buy them in a tin... so of course they no longer wanted so much fruit and vegetable..."*

These changes and others coincided with different patterns of governance and new initiatives in treatment and treatment ideologies, of scrutiny from "outside", ethical and moral concerns, and living styles, in hastening the demise of the geographic-

occupational communities. As this type of community declined, the "Community of Interest" developed. These other developments will be examined later in this chapter.

In a later period, Ramon (1992:191) talks of the considerable expansion of the non-statutory sector, as a service provider during the 1980s, as a direct result of the Government's encouragement in attempting to reduce the statutory sector and replace it by non-profit (voluntary) and for-profit services. It is acknowledged that voluntary organisations:

> "...regard their position as closer to the community, either a local area or a community of interest, than that of large institutions such as hospitals, and also being more directly responsive to users needs." (Perring, 1992:160)

The notion of "Communities of Interest" is being presented in this chapter as a theoretical concept relating to the evolution of mental health services today. Unfortunately, Ramon mentions nothing about the history of voluntary involvement in mental health issues and how this relationship began. Barham (1992), in exploring the "closing of the asylum", mentions current voluntary services little and their history not at all. Barham and Hayward (1995) deal very much with current issues in exploring factors surrounding "relocating madness" and although mentioning services such as MIND, do not explore the origins of services. Gittins (1998) in narratives of Severalls Hospital does not mention voluntary services at all, nor indeed if they existed within that institution.

This emphasis on recognising the early history of voluntary services in mental health is new with respect to including their contribution to the development of hospital communities as a whole. Data will be explored specifically in relation to the founding of voluntary services at St Crispin Hospital, which was, it has been

revealed, the first League of Friends in a mental hospital in the United Kingdom. It was founded in 1952 and was well established by the mid 1960s (See Appendix Four). This has not been recognised in previous histories examining hospital-based services, either because it was unknown or not felt to be important. Although the service was not at first seen as influential, it later became so:

> *B. "Well, the... The League of Friends had been.... set up just before I arrived if I remember rightly...the first in the country ... in a psychiatric hospital, you'll have heard that ...but it...it doesn't stick out in my mind as a major factor. I mean, it was important ...as a precedent and was beginning to do things but ...it doesn't stick out in my mind as a dominant force or dominant thing in the way that it became ...years later."*

This initiative, and others like it on a national basis, can be argued to have contributed to a beginning of the development of "Communities of Interest" first in addition to and then finally superseding the traditional "Geographic-Occupational Community" within which the hospital based service had previously existed. It was a time of unpaid but interested outsiders focussing their gaze on the institutions and coming to the hospitals in an attempt to initiate change and to provide a public service.

An early recruit who was a founding member of the League of Friends recalled her reasons for being attracted to mental health issues. The mother of two young children, "L" was living with her husband who had not long been long demobbed from the services. She had always had an enquiring mind and liked to attend classes in her spare time:

> *L. "Well I've always...I've always gone to some kind of evening classes and I went to a...the big thing was uni... a...the WEA and university extensions...'*
> *...I went in ...I think two three-year stints with different tutors ..."*
> *"...and I did philosophy in ...yes, mainly philosophy and psychology and... I always went to at least one class even, you know, throughout with children and all that..."*

"... there was a Cambridge (Note: held locally in a university annexe) one and they did some very .. very good courses and in fact... they did a couple of three year courses on psychology which was the up and coming thing at that time and that fascinated me. It was at that point I thought I should have studied this..."

Exploring ways of obtaining further education and involving herself in an area of useful activity in what was seen as an exciting time of innovation and change after the privations of war, the comments of "L" also reflect her view of what could be seen as the limited expectations of women at that time:

L. "...I think that I was very ...keen that I shouldn't just be a housewife but I didn't mind particularly that I didn't have a paid job... if I could... study or be interested in ... public affairs, social affairs or what have you ...I mean I wanted to be something more than just a ...you know a...just a housekeeper but...I don't think it...it occurred to me to worry too much...because just nobody did..."

In addition, in the post-war period and with the demobilisation of men who had served in the armed forces during the Second World War, many women were being displaced from the domain of public employment. This, it could be argued, left a pool of talented women willing and able to initiate voluntary work. The route that "L" followed in becoming directly involved with mental health came via networking within a women's interest group as she adjusted to a move from Boston in Lincolnshire:

"I joined the Business and Professional Women's Club...they were told that I wasn't one but they had a certain amount of ...leeway for people who weren't who were friendly with people who were to join in..."

"...it was my first contact in Northampton because we...before we came to Northampton we went to Boston and ...we became friendly with a lady there...or I became friendly with her and...she took me along to the Boston club so the Boston club introduced me to the Northampton club... and so somebody came and sort of ...called on me and got me into the ...local club so... that was really how it started..."

This interest led to pro-active involvement by the club in public services within the town:

> *"...to play an active part in social affairs and...and so they did various projects and one of the things that they were just about to do when I joined was...to look into ...youth clubs and how they would work and if they were run...and ...what good they did etcetera and ...so I did one or two surveys and went along to these clubs and did reports..."*

This activity led "L" to eventually being asked to become secretary of another organisation in Northampton and ultimately into contact with another very dynamic woman, Mrs "X", who had also become powerfully influential in the future development of St Crispin Hospital and was to chair the Hospital Management Committee:

> *"...do you think you might like to be secretary...the Standing Conference of Women's Organisations?...that's an organisation where you get two women from all clubs in the town, they meet every two months and they discuss public affairs ...and of course that appealed to me as well so I did that ...and after I'd been secretary for a while...we had various speakers bringing up topics of interest, we had as a speaker...the newly appointed chairman of St Crispin ...Hospital, who was a woman, which was unusual in those days...and ... and she was also new to the hospital services...she'd...she's come into it because she broke her hip and she spent her time ...reforming ...the (unclear word) orthopaedic hospital and the board was impressed...Yes...and the board was impressed... and ...and so, they made her chairman of a... St Crispin's."*
>
> *"... she was very dynamic and...forceful woman for us you know and ... so ...she...she ...went into it with great gusto..."*

The nature of the League of Friends that was envisaged differed from what had preceded it in general hospitals and was a reflection of the perceived isolation of most of the long-stay patients in the institution, some of whom would have been resident for many years. At that time patients would usually not have owned even their own clothes and had little choice in even highly personal items. An everyday existence based on such privations, together with all the other negative aspects of institutionalisation, led to a loss of individuality within this mass of patients.

The deliberate initiation of an interpenetration of different communities, including previously "hidden" areas of the institution with a motivated group of people from the wider outside world, had an important effect in initiating "Communities of Interest". As noted, these developments took place at a time, in the immediate post-war period when political, economic, social and organisational changes were taking place. As part of this process, some patients in mental hospitals were also beginning to receive greater freedom of movement within and around the institutions. This led in turn to a greater awareness among the general public of mental health patients around them who had, in the past, often been concealed away behind the walls of the institution. The element of potential risk that this may have presented increasingly became part of public consciousness. As discussed earlier, this was allied in turn at St Crispin Hospital, to changes in the make-up of the local population with new residents moving in.

On being invited to see what he described as "the closed wards" by the Medical Superintendent this early post-war volunteer recalled her shock at what she saw:

> *L. "Anyway... we went round and...we went to one of the women's wards ...which was a closed locked ward ...and this was the thing that had the most impact on me, he unlocked the door and there was a terrific surge of women sort of rushing to the door and shouting and screaming and ...gesticulating and dancing about and ...we just stood there for a while and in due course they calmed down a bit and then sort of kep...came and crept up to us and touched us ...you know sort of tried to be friendly..."*

Initially the volunteers had some concerns about acceptance into the old hospital community by the professional staff and in particular, the nurses:

> *L."...I think I...occasionally ...I ...was a bit concerned about ...whether the nursing staff thought that...we were ...we were being intrusive."*

The public image of mental illness was one of fear within the wider community and beginning to rectify this was another objective outlined by "Mrs X":

> *"she ...either preferred the idea or formed the idea that if you then had Leagues of Friends before, that mainly they were making...they were for making money, you know, for the hospital but she had the idea that if you had a League of Friends that it was there to kind of ...befriend patients and ...help with their public image (unclear words) with the public image etcetera, that this would be a good thing ..."*

The League of Friends not only provided friendship but also involved themselves in skills training. A minute note of the Medical Advisory Committee for February 1955 records "that cookery classes are arranged by The League of Friends".

At the time that the League was established, a chronic shortage of staff continued to lead to problems (See also, Chapter Four). This shortage was making it difficult to introduce therapeutic measures within the hospital, leaving space for volunteers to carry out activities such as cooking that would be developed by occupational therapists and rehabilitation specialists and again later, other voluntary organisations.

One limitation on activities related to concerns about volunteers taking patients out of hospital. Issues of security, worry about general risk and concern at in-patients being outside of a professional "gaze" were prominent at this time. However, "L" recalled some patients being taken out for tea at their homes by some members. Furthermore a simple activity such as, the sending of Christmas cards to patients, although seeming mundane at first, is important if it is remembered that many may not have received one for many years. These activities began a gradual process of combating the loss of individual identity that many had experienced:

"..we had permission ...to visit...patients on the ward...so....if we made an arrangement, the Matron, you know, sort of fairly informed them (unclear word) just dropping in. We could...anybody who is so minded could go and have ...and have a chat with the patients on the ward ...and then when we sent them a book or a Christmas card ...the first Christmas which was a mad thing to ask ...and ...later on we sent ...when they began to come out ...we...we perhaps had somebody to tea or something like that. It was a fairly informal ...way of having a chat with somebody."

In time, "L" believed that more training was taken on by the staff and the League of Friends began to concentrate on other areas of work:

"I imagine that.. as time went on and the OT's and the ... staff ...ward staff would be doing more and more and they would take the patient...I mean we had to shop to come into the hospital...but then the ...staff had permission to take them out and they used to take them out ..."

"...but then that was a sort of thing really that the staff could do much better and...so in time they began to do ...all those...sort of more specific training things..."

(See photograph on next page)

Figure Eight: A cookery class at St Crispin Hospital in the late 1950s – early 1960s.

Nonetheless, these kinds of activities, teaching living skills, were undoubtedly pioneering and were being carried out by voluntary workers. The make-up of the group and the reason for members interest in mental health in the early years was felt by its first secretary to be fairly specific, although this changed later:

> *L. "...we didn't have much effect in the community but, as secretary I had people writing to me and saying ...I'd like to join the League of Friends ...will you send me an application form or how do I do it? ...or... or have you ...and we got a number of people like that ...I didn't realise until afterwards but I'm almost sure ...looking back that most of them were relatives of people who'd been mentally ill ...short-term who were interested..."*

What was demonstrated in this sense was the willingness of some individuals to become proactive in pursuing their interest and supporting family and friends in a voluntary capacity. This has subsequently become a characteristic of many interest and self-help groups.

The objective of the friends group to influence public attitudes to mental illness is demonstrated in the interview data and reflects a belief that this was achieved:

"The impact we had on the hospital ...I think I...that ...some people within the hospital ...felt that ...they were being accepted ...as part of the community and that they weren't yet...the people weren't afraid of them because... the early days when we were trying to recruit ...some people ...were so frightened they wouldn't even walk up Berrywood Road...you know, it was a ...(laughs) ...yes...shudder, shudder...they didn't understand and they didn't want to an...so ...I think I think that ...I think ...people in general thought that ...they were being accepted and valued in the community to a degree in a way they hadn't been..."

Initiatives such as these were important in helping to combat the stigma of mental illness. The "Community of Interest", that these data reveal, began to develop in this early form was based around a co-operative relationship between patients, volunteers and staff. The involvement of volunteers began to develop greater contacts with the world beyond the "Geographic-Occupational Community" that was now breaking down. As already noted in respect of a comparison between "old village" with its more tolerant and integrated attitudes and the less tolerant "new village" this opening up of the institution took place at a time when relationships with some of the community local to the hospital was beginning to change. As already explored in the notion of the "new village" earlier in this chapter, less tolerant attitudes could lead to the perception of risk associated with greater patient freedom. In the instance cited, this was of a potential risk to children a subject that has, at present, a very high profile and will be considered again in Chapter Six, "The Community of Risk".

"As well as the development of the "new village", other developments were taking place within the institution that helped to initiate change. One of these will be considered next.

(7) Multi-regional, multi-ethnic, multi-cultural hospital communities.

Continuous staffing problems, discussed in Chapter Four, existed during the whole period covered by this study, and led to the development of a partly multi-regional workforce from the 1930s to a multi-ethnic, multi-cultural one with a pronounced drive to recruit from overseas following the Second World War.

> *F. "...I must have been more or less...there was one more...one more lot came from Austria after us..."*
> *"Cause then, I ..I think they went over to Ireland and recruited in Ireland, they brought some Irish...quite a few Irish students came over from Ireland then.."*

An effect of recruitment from other ethnic and cultural communities can be the introduction of new ideas and the initiation of change. Early recruits to St Crispin in the immediate post-war period came from Europe and in particular, Germany and France. An early problem could relate to language. As one recruit who began in the early 1950s and originated from Austria recalled:

> *"If you passed your final, you got 60 pounds...what I got..the other thing is that what sort of stands out was that due to the (unclear) was CW, I..I think that man, he deserved a medal, because all the students were foreigners because there were... there were Austrian students, there were French students, French girls.. as school was in, none of us spoke any English or hardly any...any English and he had to cope with us."*

From the 1950s and 1960s onwards many nurses were sought from the West Indies and had the advantage for their employers of speaking English. All those who arrived at this time helped to alleviate the problems existing in the immediate post-war period. One recruit to The Towers Hospital in Leicester in 1962 was born on Antigua and educated in Monserat:

> *E. "They... in the Caribbean it was advertised in the Caribbean islands that they were short of nurses and local other employments... labour force on the whole in England was very short. In Barbados they were interviewing people for ... hospitals and various posts around England but then I came with the intention of ... to do my nursing. I wasn't one of the recruits in the Caribbean. I came here to a family friend and then applied for nursing ..."*

When "E" first joined the staff, she was initially shocked at what she saw:

> *"Then I was asked, would I like to see the wards? and I thought well I need to see what I'm letting myself in for having accepted.. to take up the opportunity for training there.. I was shown around by another West Indian nurse on the wards.. that was another shock for me because I saw fire on the middle of the ward and patients were sitting around them in chairs with this big sto... coal fire and I couldn't understand what was going on, what it was all about and the noise was shocking. I turned and I asked her how long has she worked here, she told me she has been there now for three or four years. I said how do you tolerate where are the patients you're nursing? She told me these are the patients this is a psychiatric hospital and that's what you expect."*

Her experience and her upbringing prior to joining the staff had, felt "E", provided her with skills that helped improve the lot of those she cared for and in particular, elderly patients:

> *E. "... in the sense of having dealt with people.. we were learned to develop very quickly, mature very quickly in the Caribbean, so I felt that I had attitude to bring with me and also the culture ... when I say the culture is our approach to various areas and.. various situations because your always caring for elderly people in the West Indies. The family gets tended family.. was very much a close link where you will find that though I did not have any immediate elderly family in the West Indies I had the elderly ... person next door, living next door, I would ask to take on different calls for them like doing the shopping for them, going in getting the food ready.. when I getting, doing a bit of shopping, preparing the food so that was sort of a intermediate... contact that I had with the elderly. So I was very, I felt I was very versatile to ... have that."*

The introduction of nurse recruits from abroad, although now controversial because of the depletion of human resources from countries of origin, is revealed in this research as having a long history and of long being of benefit to the services in the United Kingdom. This benefit is not solely in terms of contributing labour per se, but can now be argued to encompass the introduction of new ideas, new energies and new strategies all of which contributed to changing and arguably improving the modes of governance for mental health patients.

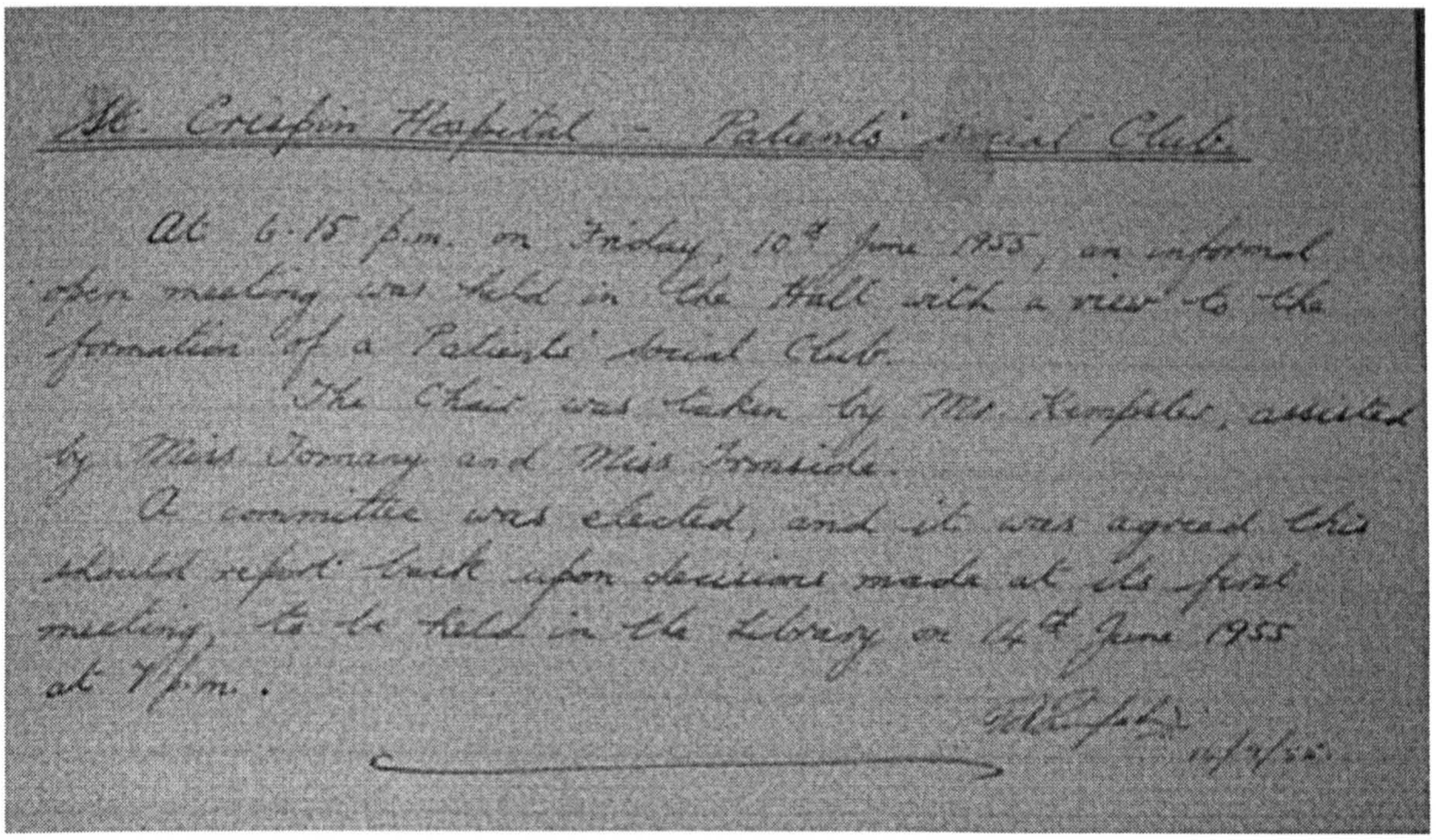
(8) The beginnings of patient choice and educational initiatives in the wider community.

The League of Friends at St Crispin went on to found a patient's social centre, a shop within the hospital and eventually a patient's boutique with the development of policies of the individualisation of clothing during the early 1970s. The patient's social centre was eventually built and opened in the early 1970s. Although some of these activities eventually became unpopular among a small number of staff, who saw the improvement of patients' comfort within the institution as being counterproductive in terms of encouraging people to live outside, there is no doubt that these innovations were important. Individual choice with respect to daily living, in terms of the ownership of items of clothing, and the purchasing of toiletries and tobacco etc. was now possible and could be carried out independently of staff.

As many of the patients had been in hospital for many years, or were admitted in their later life, the volunteers also looked to improve their general quality of life:

> *L. "...Yes...yes I mean, we actually started a Darby and Joan Club because of course there were a... tremendous number of elderly people at that time in fact, in fact most of the people that you came into contact with were elderly."*

Other socialising initiatives were developed during the 1950s. One such was a Patient's Social Club (See the minute recording the inaugural meeting below: Source - Northamptonshire Record Office).


St. Crispin Hospital – Patients' Social Club

At 6.15 p.m. on Friday, 10th June 1955, an informal open meeting was held in the Hall with a view to the formation of a Patients' Social Club.

The Chair was taken by Mr. Kempster, assisted by Miss Tovey and Miss Brooke.

A committee was elected, and it was agreed that should report back upon decisions made at its first meeting, to be held in the Library on 14th June 1955 at 7 p.m.

Figure Nine: A minute recording the inauguration of the Patients Social Club – 1955.

The period of the 1950s also saw the development of a general enlightenment in a new approach to mental health reflected in the involvement of prominent local individuals such as a well known local artist, John Bird. In the redecoration of the hospital chapel at St Crispin Hospital, the faces of staff were portrayed in the images of saints in a series of murals. Although seeming fairly innocuous, this evidence could point to a wind change in attitudes to mental health at this time. This is arguably somewhat ironic. The patients had become somewhat less than human as a result of the institutional conditions they lived in (not that these were largely the fault of the staff). To an outside artist coming in, the efforts of the staff could appear saintly in dealing with such challenging humans.

An important factor with respect to St Crispin Hospital was the presence in the town of the large private mental hospital, St Andrew's, that benefited from the interest of other influential local individuals. With new innovations, including the use of art and artists, National Health Service mental health issues could be seen as becoming

more acceptable among middle class interest groups and generally larger and broader communities of interest, in the new climate. A pamphlet was professionally published to mark the chapel paintings with sophisticated artwork within it:

> *H. "...the excitement in nineteen ..I suppose it was '54 when he painted the wonderful murals.. in the....chapel or church in St Crispin's Church. If I remember correctly, St Luke is depicted and it's...it's ....Dr G's face actually...I can remember there was great excitement about that ...we all went and studied them."*

A booklet was printed for the occasion and the cover is shown next in Figure Ten.

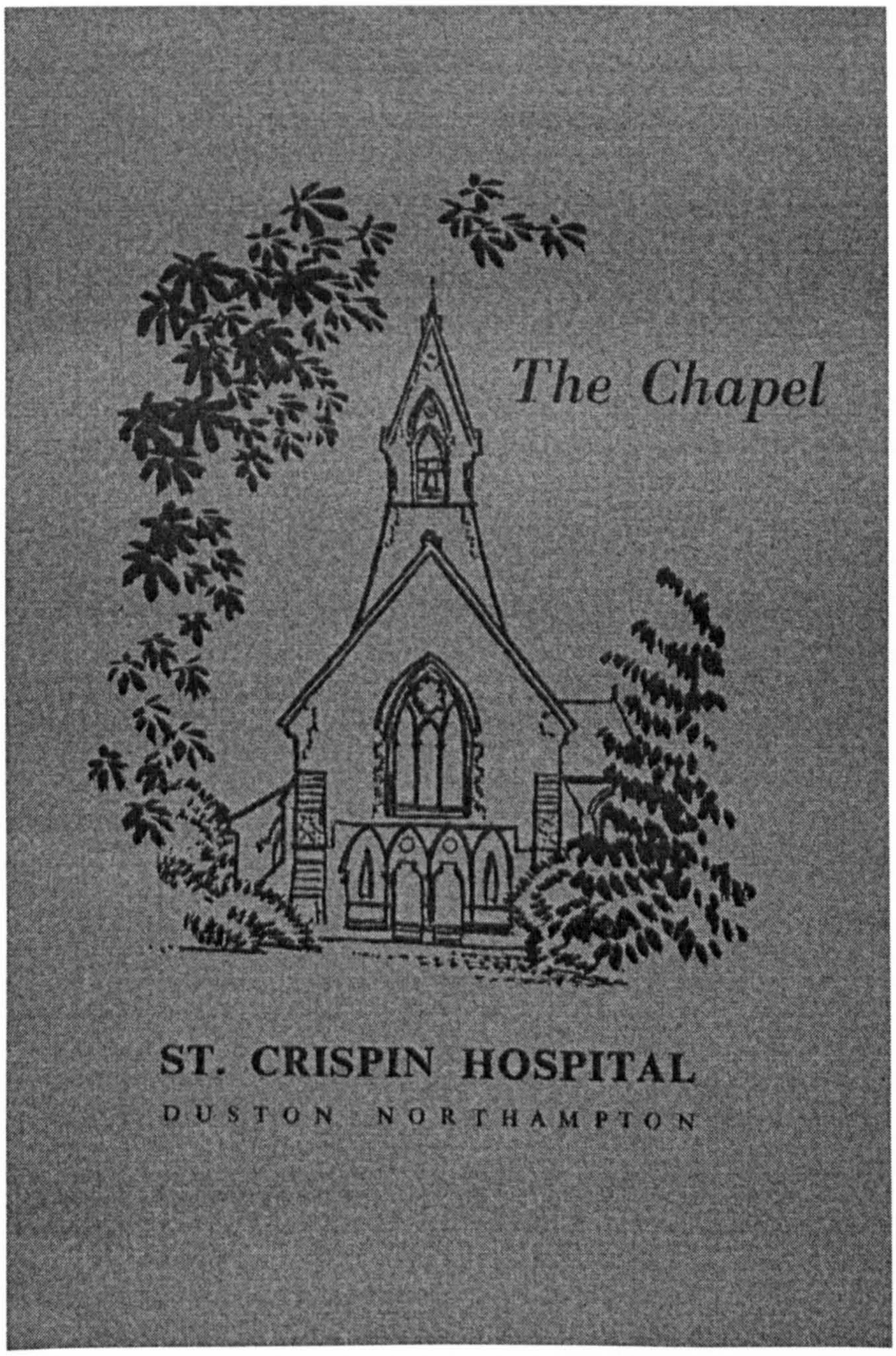


Figure Ten: Front cover of a booklet with a wood block image produced to describe the murals within St Crispin Hospital Chapel, Northampton.

In 1959, a new Mental Health Act came into force. This legislation established the concept of the "Informal Patient" and instituted a better appeals procedure for those admitted under a section. The new legislation also served to drive the processes of change. A more community-based service could have developed under the auspices of this Act with better co-operation between health and local authority services, but failed to do so. The first community psychiatric nurses began work at Warlingham Park Hospital just a few years before the Act, in 1954.

The process of opening up the hospitals to a broader community gaze accelerated in the 1960s. This was particularly so with the announcement of the eventual closure of the institutions at the beginning of the decade. One initiative was multi-agency and attracted national interest:

> *"...A new Medical Officer of Health for the county had been appointed. A very far seeing ....new man and this chap had also been appointed as a member of the Management Committee of the hospital...As MOH for the county, he had responsibility for...Mental Welfare Officers...employed in the county ...The Hospital itself had... 'one and a half' Social Workers ....and ...on the ... Management Committee he...was concerned to try to do something. One of the things he did was to initiate a... year long project...of public education jointly between the staff of the County Medical officer of Health, the.. British Red Cross Society in Northamptonshire and the St Crispin staff...and the aim of this was...to...give a years ...sort of project of aiming to provide...education to the public about mental health matters and the concept of mental health as (unclear word) from illness and the idea that..of community care.. 1962..."*

The progress of the Northamptonshire Mental Health Project of 1963 at St Crispin Hospital in Northampton came under national focus with the involvement of the BBC. The beginning of the conceptualisation of modern "care in the community" had occurred in 1961 and any such development was topical:

> *J. "...and this had been ad...adopted as a...a major project by the BBC so that there was a ...a...survey of about a thousand randomly chosen people from the county done on a questionnaire basis before it all started and another one on*

another thousand people after it finished to see if there was any difference in..in public knowledge or public attitude and there was a very carefully devised questionnaire...the interviewers had been trained and all the rest of it and a number of us, some from outside and some of us on the staff of the hospital spent the year going out blathering to anybody who would listen to us.. about mental health and ..what was happening and where we were going..."

There is oral evidence that the BBC recorded film material within Duston. A retired senior nurse remembers Michael Barrett, interviewing individuals in a public house local to St Crispin Hospital for a "Panorama" programme and asking customers if they knew they were drinking next to psychiatric patients and what they thought about it.

C. "I mean, we did a Panorama programme once and the ...Barratt was the presenter in those days...Michael Barratt...And he said.... we were talking about the programme in setting it up and we mentioned this about the local people. He said 'we'll have someone coming in to the local pub and saying this man is mentally ill.... you may be drinking along someone who is mentally ill.' This was part of the education of the wider public and it was one of the early television programmes. They came to do a slot but they actually did a full programme on it because it fascinated them so much because the chappie who was invited in those days... The television cameras were critical to about 10 inches or something and they had to get this chap to walk up the line and of course he went... the local landlord who knew all these patients gave him a pint and because he drank about 6 of these pints while he was trying to walk up the line to...and properly focus but... He had the time of his life this chap he was a Scot. But it yet was again ...they picked it up that the local people understood and knew and had much more confidence in what was going on in the hospital than people like the group of new people who came into new houses living in Duston for the first time."

Enquiries by the author at the BBC archive indicate that this film material is now lost and believed "wiped".

At the end of the year of the local 1963 mental health project, nothing much appeared to have been achieved initially. As remembered by "J", a doctor involved in the project:

> *"...In the end it ...we were all exhausted (light laughter) and ...the full analysis of...the....interviews at the end of the year didn't really show any change at all...but (said with emphasis)... in the years that followed, things happened ...The Northamptonshire Association of Mental Health was founded ...The...Industrial Rehabilitation Workshop, now on the Berrywood Road was set up by The Junior Chamber of Commerce (said with emphasis) ...the then chairman of ... which had heard about this during the ...that year..."*

However, it was felt that the effort had initiated lasting change as old barriers were broken down and individuals became known in different organisations:

> *"...well as a result of this a lot of people from the mental health field got known...around the county (unclear word) 'that fellow who came and blathered at us until we were bored ...stiff' but...lots and lots of... meetings of one sort and another, people would be invited to go and talk to...Mothers Unions or...you know, all sorts of things so that...the hospital staff were seen as...more or less human by a lot of people who had only heard of 'the wood' and 'don't want to go there', you know?"*

It is important to note, however, that although these developments have a positive and optimistic hue, the seeds of concern about potential risk as services tried open outwards were developing at the same time, among some within the general public. More strident objections, in particular towards risk in community care, have arisen in the later history of mental health service provision. These will be considered in more depth in Chapter Six.

One outcome of the countywide initiative of 1963 was the incorporation into formal written hospital policy of a recognition of the importance of voluntary services in a development towards community care. The document looked to the future but also recognised the achievements of the range of voluntary services then available as the service broadened the scope of the supportive community:

> "There are many other important aspects of voluntary work in this field already being done, especially the help given to the hospital by the St Crispin League of Friends, and to the local authority services for mentally handicapped by the Northampton, Kettering and District and Corby branches of the National Society for Mentally Handicapped children. Many other societies already do work of extreme importance as regards mental health, e.g.

W.V.S., (Meals on Wheels and Clubs) and O.P.W.A Services (clubs, visiting)."

The statement also outlined a set of objectives that recognised that "some of the major problems in mental health cannot be tackled by statutory services alone" and recognised the importance of co-operation with voluntary societies. Five points were outlined as the way forward:

(a) The abolition of ignorance and prejudice as regards mental disorder.

(b)The establishment of aids to community care, e.g. – social clubs – as "stepping stones" for ex-patients, helping them back into full community life – "bridge links" for longer stay patients to help social rehabilitation, e.g. entertaining patients at the home of a volunteer, - "good neighbour" visitors to patients returned to their homes.

(c) The encouragement of mental health research by financial support.

(d) The prevention of mental illness by such services as Samaritan work amongst would-be suicides, action against loneliness in the elderly, relief of stress situations by the hand of friendship, etc.

(e) Close co-operation with statutory services in some aspects of the rehabilitation of patients, e.g. providing sheltered workshops or perhaps an industrial therapy organisation, run by business people on business lines to help the re-employment of patients.

The document concluded by commenting on the influence in many parts of the county of the Northamptonshire project of 1963 (Archive material - Northamptonshire Record Office). A leading role in these initiatives was played not just by medical professionals but by others including from the nursing and voluntary sectors. However, for doctors in particular, not to have been seen to have taken a leading role could, in the climate of legislative and social change that existed, led to

a loss of power and in particular, their perceived pre-eminence as leaders of the clinical team.

(9) New approaches – physical therapies.

In this section we turn our attention to developments in physical treatments available over the period from 1935 to1965. New treatments were introduced in the 1930s following the Mental Treatment Act (see Chapter Four). Units were built for the new voluntary patients within which these treatments were carried out:

> *H. "So therefore the Pendereds were built.. two divisions, male division and the female division and.. there was also a villa attached which was intended for the patients once they had received treatment that could go into this villa.. almost as a convalescent place, you know, this sort of thing. So.. but then what was treatment?"*

Some of the treatments carried out at this time are considered bizarre now. This was a time however when doctors had little else to offer.

> *J. "...this was ..before any...any of the tranquillisers or anything like that. There was Paraldehyde and Phenobarbitone and ...Barbitone...Oh yes, 'straight' ECT"*

"Straight ECT" meant the administration of electricity to the brain of a conscious patient who had not received a muscle relaxant. The patient was therefore physically held during the grand-mal seizure that was induced. Injuries sometimes resulted, including fractures.

Talking therapies, or psychotherapy, although pioneered during the First World War for cases of "shell shock" were still little used. Other treatments used at the time have recently been the subjects of a renaissance among the rich and fashionable:

> *"... colonic lavage was considered to be important and also was prolonged bathing... this was the patient who was... very manic and in a highly disturbed*

state and would be immersed in warm water for considerable lengths of period with constant nursing observation and so on and... now this was all built in to this hospital. Certainly it was considered to be important..."

Other services providing activity based therapies were in their infancy or limited in scope:

J. "...The occupational therapy people such as they were, were ...very limited and not formally trained ones. The Pharmacy was ...had been very limited ...Paraldehyde, Phenobarbitone etcetera and then gradually, it was going to be expanded because more things were coming."

Outpatient activity was very sparse by today's standards in the early part of the 1950s. However, the first of a new generation of drugs, based on the Phenothiazine molecule, was beginning to be introduced as major tranquillisers:

"...there were a few Out-patient Clinics...one or two in Northampton at the General Hospital and one in Corby I think, once a fortnight or once a week and that was all...and this again was before...well ...Largactil ...was just ...just beginning to be available...that was the first of the Major Tranquillisers but before Anti-Depressants..."

The data reveals that the effect of a brand form of the Phenothiazine group of drugs, Chlorpromazine, brand-named "Largactil", developed in 1952 and introduced clinically in 1954, is recalled in oral accounts as effecting dramatic changes in some patients:

F. "So ...and you could see the change in the patient when Largactil came in...you know...and seclusion...i...it sort of faded out and then they had sort of half seclusion as they called it... they called the horse box where sort of half doors, you know...patient wasn't locked up, the top part was open. Usually sometimes (unclear) some of us had to sit outside to stop him from jumping over the top part? when it was unlocked."

This drug, as well as being seen by doctors as their first really effective chemical tool, was the first in a whole number of drug therapies. Another drug, "Tofranil" (Imipramine Hydrochloride), was an early anti-depressant. Many others have since joined the pantheon of medicinal treatments for mental illness. At the time miracles were claimed and expected of Largactil. As related by one male nurse:

"...and undoubtedly it did have a dramatic effect particularly in the case of some. People that had been just regarded as... well cabbages... you know, to use the vulgarity of it all that... that the fact was that they were so far gone that they could never ever respond to anything at all ever again but were in fact responding and literally coming into life. I mean, I remember of one particular instance of... by then I was in... administrative... aspects of life in the hospital and going... doing a ward round one morning and going through a ward and someone said to me in quite a cheerful voice, 'good morning Mr ----, how are you?' and... I just said 'hello, how are you' and... and I walked on a few paces and then... 'God who was this that had said this to me' and I looked round and I was completely taken aback by this particular patient that had spoken to me and I had never, ever, known him to speak and it was said that he hadn't spoken for years and this was the sort of thing that was happening. But then of course you would... had to understand that this was like Rip Van Winckle waking up from the great sleep and the fact was, here they were, suddenly coming into a world that they knew nothing about, everything had changed."

For patients, the memory of the effect of Largactil (Chlorpromazine) is not always positive:

A. "... either Melleril or Largactil or one of the other shits, and umm... and... you can't function anyway, so you were slobber your way up to the... you know, if you could make it to sign on would be a miracle, because... you know, the effect of the Largactil is completely... you know, its bad... its two bottles of bad vodka... it just fucks you completely... so you know, you can't really do anything at all. I had friends who were re-admitted 'cause they fell asleep in the middle of their work... and that was the result of the drugs that were... you know, supposed to stabilise us..."

Since the introduction of this drug and related products there has been a "chicken or egg" type debate about the relative merits of drug therapy and other initiatives of the time. The so-called "open door policy", for example, has been cited as of at least equal and possibly more importance than chemical treatments in the changing nature of the institutions. It is not clear whether the drugs made possible the open-door policy, or whether the open-door policy would have developed in any case.

In a different respect, the unlocking of wards began in the later 1950s at St. Crispin with the consequent ability of patients to move about the hospital. Sometimes, in

some hospitals as in St. Crispin, authority figures as, for example, a Medical Superintendent, a Matron or Chief Male Nurse would make sure these changes were implemented and continued. In practice, even with main doors unlocked, some patients would still be confined to wards and, even today, locked doors are still very much in evidence in modern units.

It has also been shown that other variables came into play at the time Largactil was first introduced. One possibly influential factor that may have benefited patients who were put on the drug was an increase in attention with supplementary procedures and treatments:

> *F. "Largactil came in, Largactil at that particular time was used in small doses, ten milligrams and you had to take a blood pressure and pulse and everything. Now the...they're dishing it out...(claps hands) you know..."*

Gittins (1998:212-213) acknowledges in relation to Severalls Hospital, that:

> "Largactil greatly reduced violence and terror in psychotic patients (and possibly also in deputy matrons). Although it did not turn out to be quite the cure originally hoped, it enabled a more relaxed regime to be put into effect on hospital wards...."

In addition, new drug treatments meant that staff attitudes also began to change in facilitating the introduction of programmes of rehabilitation and habit training on the so-called chronic wards of institutions as part of the therapeutic drug intervention. The evidence emerging from the data reveals that ex-staff present at the time and taking part in this project, support the belief outlined in Chapter One, that the introduction in the post war period of new, neuroleptic, major tranquilliser drugs such as Chlorpromazine and new anti-depressants did help to initiate change. These changes made possible new initiatives being mooted that were ultimately to take the institutions away from localised work-type communities to geographically scattered premises with limited interventions and information and communication-based

programmes. There was no "chicken and egg" but a complementary change in attitude and approaches to care, as well as chemotherapy. They were inextricably linked. What these new treatments also did was to reinforce a psychiatric medical model approach and enhance the power of the profession. At last, as noted, they had a capacity to treat on a par with their colleagues in general medicine.

(10) New approaches – "therapeutic communities".

Some individuals working within mental hospitals, particularly from the 1950s onwards promulgated the importance of the community as a therapeutic tool in its own right. Seen as rather different from other, more mainstream, colleagues, less emphasis was placed on physical treatment and more on social interaction. Tucker (2000:10) defines the "Therapeutic Community" approach as:

> "Fundamentally a socio-political approach in the sense that it takes as central a conception of a person whose essential identity is both dependent upon and constituted by their relationships to others."

Although, as already mentioned, "talking treatments" had been pioneered during the First World War for cases of "shell shock", Maxwell Jones and Tom Main among others developed the approach further during the Second World War (Tucker, 2000). Although some specialised in psycho-therapeutic approaches, most also recognised the importance of interpersonal aspects in the search for cures:

> *J. "...I think...human care. I suppose people giving...giving people time if not much space... within which to recover....The relationship between the Nursing Staff and the Patients undoubtedly was a ...a...a very important therapeutic influence, particularly in those with a ...a non psychotic illnesses. Perhaps more than I realised in the psychotic ones as well but...there was a fair amount...attempt at simple psychotherapy by the Doctors ...in limited time obviously ...I'd have said that more than anything else and ...and simple...sedative approaches to people with...severe anxiety illnesses...pretty limited and...and really revolved around ...personal relationships I think ... but not a ...not sophisticated relationships, just ordinary human ones..."*

This type of work may have been developed within enclosed units within institutions or later developed in units such as those specialising in Child and Family Guidance outside of hospitals. The innovations, although not embraced by all, emphasised the recognition of individuality within the client group, allowed free expression and emphasised more the need to work with people rather than simply treating, or doing things to them. A characteristic of such communities was that they gave less emphasis to physical treatments such as drug therapy and Electro-convulsive Therapy (ECT) than those who followed the medical mainstream. The essential nature of these units also, typically, involved an environment where lines of hierarchy between staff and patients and staff and staff were lower key and sometimes blurred.

(11) Rehabilitation and the re-emergence of the "individual".

As the old institutions began to change, the experience of adaptation to life outside did not always appear to take place in a planned way for those individuals who were the recipients of the service:

> *"...and there are an awful lot of people nowadays who've had the similar experiences to myself, in the old style mental hospitals, who were then put into the community and initially there were no support services at all. The hospitals were closing and people just had to get on with it."*

Experiences may have reflected gradual change for others:

> *O. "...and then when I went on dormitory work, then I got town parole by '54... February I think it was, and I started out on that... surprising to find myself outside after about twenty years... yes..."*

The beginnings of the rehabilitation movement and the development of the process as a speciality began with initiatives such as the Industrial Rehabilitation Workshop at St Crispin Hospital. This unit was designated to retrain patients and ex-patients to

return to the world of work. This unit was seen as different to industrial therapy as the name implies. Nonetheless the emphasis differed from the farm and other industrial activities even if the results did not. It was seen as an important new initiative in the early 1960s. As remembered "D":

> *"...ideas was beginning to.. get around from other hospitals. I remember in particular the...one of the hospitals in Coulsden, was it Cane Hill or...? Though the two were....(unclear) an Industrial Workshop had been set up and... I....heard about this...thought it was a good idea ...got permission to go and visit... and went and saw them and brought back some ideas. That I felt was a..a good example of ....shared learning from one hospital to another...."*

Living skills training by dedicated rehabilitation teams, primarily from the 1970s onwards, helped long-stay patients to move into the community. Some lived together in "group homes" where they may have been supported by Social Services and the Community Psychiatric Nursing Service. Others with greater needs moved into staffed residential accommodation. Some managed on their own with just support from primary care services. Whether or not much of this change was driven by the economic needs of governments to reduce the costs of institutional care (which, as well as being costly, exposed institutional practices to outside scrutiny and hence modes of governance to criticism), the result was both the greater visibility of the individual who was thus rendered amenable to rehabilitation strategies. The rehabilitation services developed the processes that began and eventually succeeded in finally emptying the old institutions. Some residents were moved into group homes with developed social networks of support. These initiatives commonly involved joint establishing, supporting and supervisory work between health and social services. However, critically, the services that were set up did not necessarily involve integration with society at large but could also lead to ghettoisation. In considering the use of support groups for group home residents, McCourt Perring (1993:187) comments:

> "...where residents and day centre members do not have open choices to associate in this or other networks, it may more accurately be seen as a continuing form of segregation."

This comment is again supportive of the notion outlined in Chapter Two that inclusion in society outside of hospital is not necessarily synonymous with integration. It also implies that although now outside the walls of the institutions, scrutiny and control, being "policed" as perceived by interviewee "P" in Chapter Four (page 153), may continue albeit in a more subtle form.

(12) Conclusion.

This chapter has explored the evidence revealed by the research process of some of the changes engendered in concepts of community within mental health during the period of approximately 1950 to 1965. It has also considered some of the outcomes of these changes. The chapter identifies policies, initiatives and developments that helped to instigate those changes. The chapter also introduces theoretical conceptualisations of community that fit comfortably with these developments. These are the breakdown of the old geographically and work-based "Occupational-geographic Communities" discussed in depth in Chapter Four and the development of relatively scattered "Communities of Interest" allied to statutory services that provide the bulk of the delivery of mental health services today. The period also witnessed the rise of patient empowerment with voluntary organisations, and the re-emergence of individuality among the client group allied to services of rehabilitation.

This chapter has advanced the analytic concept of a "Community of Interest" to capture the kernel of the social processes which seem to have been at work in the

immediate post-second world war period. Those who had by necessity stretched their self-reliance and ingenuity in wartime were now less likely to accept hierarchy and deference to tradition as legitimate reasons for doing things. Furthermore, the previous incarnations of mental health communities became, as we have seen, increasingly untenable. In the aftermath of the Nazi concentration camps, and in light of continuing Cold War era Gulag work camps in the Soviet Union, the thought occurred that large mental health institutions, characterised by anonymity, processing by numbers and lacking in human rights can be seen as compromising everyone involved. Most obviously, it compromised the patients who were now seen as being dehumanised by their treatment. But this dehumanisation was equally abhorrent to the staff, especially those arriving new to the setting in the post-war labour shortages, and in whose minds images of atrocities were strong.

Moreover, the legacy of 'only obeying orders' was now discredited, as was standing idly by and allowing injustices to happen. It was therefore in the interests not only of patients, but also of staff to change the parameters of care, for the old ways dehumanised them all. Likewise living in a society that permitted such degrading scenes was now regarded as degrading all who tolerated such circumstances, and the new voluntary gaze looking in on the institution was equally involved in the common interest in ensuring that dehumanising treatments and conditions were to become a thing of the past.

Meanwhile changes in the technologies of travel and communication meant that work communities no longer had to be coterminous with geographic communities. Geographic and social mobility changed the nature of the societies within which

"Geographic-occupational Communities" had been located. At a time when the "Community of Interest" that encompassed patients, staff and volunteers represented an impetus to greater links with local residents, the changing nature of those residents became less accepting of such contacts.

This perhaps helps to explain why the "Community of Interest" also resulted in a consolidation of the power of the medical profession in the field of mental health. Medical professionals could be seen to be charismatic in changing the face of the old asylums; the incorporation of mental health hospitals within the National Health Service after 1948 further cemented their influence on the situation, as this separated the hospitals from local boards with their broader representation of other local dignitaries; new drugs gave the appearance at any rate of an applied knowledge producing improved patient care; and workshop activity could now be re-conceptualised as therapeutic activity, activity to which the medical profession could refer people.

Chapter Six will briefly explore developments that have emerged more recently, concentrating on the increasing concern, particularly within central government, of perceived elements of risk in current community care policies.

CHAPTER SIX

THE "COMMUNITY OF RISK"

Introduction.

The following chapter will explore the concept of the nature of "risk" in mental health deriving from developments in services since the first moves to community care. Focus will continue to be placed on the services that originated from St Crispin Hospital in Northampton, over the last fifty years.

The mental health service has, as already noted, been historically associated with policies designed to contain perceived risk emanating, in particular, from the so-called "dangerous individual". The exploration will examine the historical nature of risk reflected in mental health policy and will draw on discourses that are useful in analysing this material. Oral accounts will be presented, allied to other sources, including those relating to mental health services other than those deriving from St Crispin Hospital. The nature of developments will be considered from the perspective of a continuation of the processes already identified in the preceding chapters. Chapter One identified aspects of the historical management of those who were sometimes identified as providing a risk to the safety of either themselves or others. In Chapter Two, the notion of the "dangerous individual" and legislation passed in order to placate social concerns about the control and treatment of those designated as mentally ill is discussed. Chapters Four and Five, examine in depth, conceptualisations of community arising from legal mechanisms, organisations and social aspects as well as the "asylum" building structures that developed to manage

the mentally ill. Chapter Five concentrates on the beginning of moves towards "care in the community" and focuses particularly on the development of "Communities of Interest" that were intertwined with statutory services. This chapter will explore the search by mental health service providers for formulas in the management of risk related to general cultural and social change. The chapter will briefly examine these trends under the following headings:

(1) A brief history of risk management in the "Geographic-occupational Community" of the institution.

(2) De-institutionalisation - the "Community of Interest", and the management of risk.

(3) Risk management in modern mental health services – the "Community of Risk".

First, an historical examination will explore the way that services have changed in respect of the issue of potential risk.

(1) A brief history of risk management in the "Geographic-occupational Community" of the institution.

The development of "The Risk Community" in mental health is associated with a development in society at large, argued by Beck (1992, 1999) and Giddens (1991), to be developments that may be characterised as being representative of the "risk society". Giddens in particular considers Britain to be in a post-traditional phase. He sees Britain as being a "risk society" particularly in respect of political development. Douglas (1992) explores how we view risk in modern society. The issue of risk management covers broad areas of life from environmental health to financial services. For instance, as an alternative to strongly centralised and officially governed approaches, Watterson and Watterson (2003:40) in respect of

environmental health describe "mapping hazards and risks in communities in partnership with local people." This approach has resonance with some contemporary approaches in mental health.

Risk has always been a factor in the work of the mental health services. As noted by Ramon (1992:93), risk-taking elements "...influence our interpretation, categorization, mode of relating to the client, relatives and friends." As outlined in earlier chapters, in the pre-war years mental health treatment was still based primarily within institutions and placed a large emphasis on "containment", "regimentation" and the general management of behaviour (as well as general care).

The institution-based organisation was headed by a Medical Superintendent who could be, as in the case of St Crispin Hospital, inspirational and efficient, as was revealed in oral evidence in Chapter Five (page 211). He was also recognised as a very powerful individual and was ultimately responsible for everything from appointments to general standards, including that of security, within the whole institution.

The Medical Superintendent would be known to all the staff. This included gardeners and one recalled that a particular superintendent incited fear:

> *Dr ... was, he frightened half the people... to death up there apparently, but I never had nothing to do with him really only to know him by sight, you know.*

The running of the institution was based on clear lines of authority from the Medical Superintendent down. The nursing staff at St Crispin, as in most other hospitals in the pre-war and immediate post-war periods, were headed by a Matron for the female half and a Chief Male Nurse for the male half. The ward activity that they

oversaw, including issues relating to security and safety, was based on a large element of ritual. This ritualistic activity included daily visits the Medical Superintendent along with the Matron or Chief Male Nurse. The visits contained a strong element of inspection of the running and the physical states of the wards.

Protocol demanded the correct form of address that reflected the authority of the individuals concerned. This stretched across all disciplines and occupations within the hospital. The same gardener "A" remembers his experiences in the early 1950s:

> *"Oh it...it was.. I mean if you were talking to Dr ..... it was always 'sir' and if you were talking to anybody like (The Chief Male Nurse) it was 'Mr .....' you know..."*

Many Charge Nurses and Ward Sisters were also called "sir" and "sister" by their staff during this time, a long way from today's informality. The management of risk was governed by physical containment, observation and centralised management within this hierarchical occupational community. Apart from basic training, particular skills were passed from experienced to inexperienced nurses in what was almost an apprentice system.

Guidelines to psychiatric staff in respect of hazards, although governed by local protocol such as actions the event of fire, were imparted during training. The so-called "Red Book", The Handbook for Mental Nurses, in its Seventh Edition under the heading of "special duties", covers issues of safety in a section of just four pages (1946:21-24). These special duties include comments on fire, "self injury or suicide", "violence" and "destructive and faulty habits." Some of the issues discussed, (for example, violence in respect of manic-depressive psychosis) are explored further in other sections. Some of the guidelines, such as the management of a potentially suicidal individual by the "direct and constant supervision of a

nurse" are still in practice today in one form or another. Observation is still seen as a primary means of intervention (Hardy and Minghella, 1997:244).

Updates to policy have been influenced by key events. They were reflected in policies drawn up by "procedure committees". An undated typed document attached to an observation policy dated 5th April 1974 and headed "Nursing Procedure Number 17" that was written at St Crispin Hospital records:

> "A Queen's Bench Judge recently awarded damages against a hospital whose negligence in the care of a suicidal patient led to his being seriously injured when he left his ward and made a further attempt on his life. The essence of the Judge's criticism of the care of this patient lay in the lack of communication between the nurses on duty in the ward which led, without their realising it, to the patient being unobserved.
> This case has been widely reported and has been discussed in this hospital and doubtless in many others. Understandably, we are all concerned at its implications."

Interestingly, the document goes on to say:

> "In its discussions on this topic the Clinical Advisory Committee were concerned lest anxieties raised by the case quoted above might lead to a return to a very restrictive pattern of management of patients. Our broad responsibility is to provide a therapeutic environment which we consider appropriate for our patients, and in so doing we must accept that some element of risk may be involved."

The perception of risk for staff, particularly of violence, or the accusation of negligence due to, for example a "lost" patient, can be argued to have been a continuing element of working in mental hospitals. However that there was bad and negligent practice in some institutions is well documented and much was exposed in hospital enquiries during the 1960s and 1970s in particular.

Violent incidents and other high-risk situations were also covered in the "Red Book". Advice given to deal with violent situations emphasises "never being alone". In practice, things could go wrong. Some who have worked in the mental health

services can recall the sometimes-frightening incidents in which they have been involved. One example follows. Not long after he had begun work in a pre-war mental hospital, one male nurse had an experience that was to stay in his memory for the rest of his life:

> *"I was left on this gallery with the man in the padded cell who really was no trouble at all and he was a very nice man in actual fact but... he was disturbed nevertheless. But the one that I was particularly concerned with on that occasion was a very young man who was a recent admission and was determined or so it would seem at all costs that he was... he wanted to get out, he wanted to be away... Obviously, in his state of mind as it was then, he wasn't capable of being discharged from hospital and that being so, this went against the grain as far as he was concerned... He was quite an athletic young man and constantly was clambering over the door, this half door that I spoke about. He went back on a number of occasions, I had to unlock the door, don't forget we all had bunches of keys, I mean anywhere was very secure, the wards were locked and so on and so on. So in fact... unlocked the door and just shepherd him back into the room and this happened I think on two or three occasions and then, suddenly he attacked me when I was... putting him back into the room on this occasion. He knocked me flat to the floor, face downwards... on to his mattress which was on the ground and... my head was... my face was in the pillow. He was on top of me and... was trying desperately to get the keys from me for one thing and... and I was being slowly suffocated... By pure chance, the senior nurse who was in the sick room at that time, came out of the sick room and went into the sluice room and as he went into the sluice room, turned and looked up the gallery, saw the room door open and knew about this patient and how difficult he was and ... came along to see what was going on and ... I think from that day to this that he probably saved my life because afterwards, this patient incidentally, later on recovered and he was discharged, but he said at the time, the object of it all was really for him to strip my clothes off and ... because he... he wasn't dressed you must understand this ... he was just in a sort of night shirt and... and that he would... have put my clothes on and had my keys and would've just got away. So that really was... one of my narrow escapes early on."*

This incident is indicative of the way potentially dangerous individuals were managed in the pre-war, and generally immediate post-war institution. The emphasis was on physical containment within a defined space (in this case a padded cell). The description of the incident provides clues as to how individuals were denied space as a means of control. It could be that the patient involved in this incident was simply being isolated away from others with a half ("stable") door keeping him in. On the

other hand, he might earlier have been nursed in complete "seclusion" with the whole door, both top and bottom, closed. In this case, having the top of the door open was a means of providing some relief from this situation prior to him possibly being allowed eventually to go back onto the main areas of the ward. A Handbook for Mental Nurses (1954:292) defines seclusion in the following terms:

> "...the isolation of a patient, for any period of time between 8 a.m. and 7 p.m. (in England) in a room of which the door is fastened so that he is unable to leave it at will."

The stating of times implies that the door could be locked all night without it being classed as seclusion. Any form of physical, or chemical, restraint had to be authorised by a medical officer and a record of an occurrence and its duration signed and kept by the Medical Superintendent. The Visiting Commissioners of the Board of Control had then to see such records when they visited an institution (Narrative evidence).

Medical personnel made sure that they "prescribed" and controlled such physical interventions. This medicalisation of the management of situations involving risk occurred therefore at a time when doctors had very few effective drug or other treatments. Much emphasis was placed on the "psychiatric assessment", by doctors, who alone claimed the level of expertise necessary to decide appropriate care. Little, in theory, could be done without their authority.

In holding this jealously guarded authority, based on a claim of special expertise, doctors have maintained a pre-eminent position in mental health during the entire history of the services. Beck (1992:210) comments;

> "Medicine alone possesses in the form of the clinic an organisational arrangement in which the development and application of research results to patients can be carried out and perfected autonomously and according to its own standards and categories in isolation from outside questions and

monitoring. In this way, medicine as a professional power has secured and expanded for itself a fundamental advantage against political and public attempts at consultation and intervention.
These are the conditions under which a *'policy of faits accomplis'* can be conducted and extended to the cultural foundations of life and death. The medical profession thus finds itself in a position to subvert criticism, doubts and dictates from outside by the production of new facts."

This claim has also made the medical profession a powerful political lobbying force.

In practice, many nurses had their own expertise, often handed down from colleague to colleague or even within families (Nolan 1996). Nurses, however, were expected to submit to medical instruction. Nolan (1996:54) comments on the role of the attendant in the early days of the asylums as one in which they should:

"...stand guard at the boundaries between rational society and the chaotic world of the mentally ill, between high status doctors and uncivilised patients. The attendants protected the medical authorities from the contamination of patients..."

To the knowledge of the author, during the late 1990s in Northamptonshire, nurses were allowed to raise levels of observation but never to lower them without medical authority. This remains the case to the present day.

Perceived risk, where it existed, could take forms other than the fear of violence and might in a psychiatric hospital, as in an isolation or general hospital, take the form of concern about disease. The following account from a male nurse relates to tuberculosis:

"There's one thing that I've forgotten here, also associated with this particular ward, was a TB ward and ...this was a ward of twelve beds, all of the patients who were...nursed on this...in this area were acutely tuberculous and...it was one of the places really that...I...I disliked most of any really because it meant that...when you came on duty, at half past six in the morning... a person like myself would have to go into this area and...if the weather was good enough, the sliding doors would be opened so that there was fresh air the whole night through and indeed...during the day time as well

but if the weather was inclement, these were closed up...and quite often it wasn't a very pleasant place to go into first thing in the morning."

At this time, Tuberculosis was a major problem. Antibiotics had not yet been developed. Victims of the disease would usually be sent to an isolation hospital and treated largely with fresh air and a nourishing diet. The fact that the sufferers mentioned in this narrative had a mental illness meant that they had to remain within the institution and be cared for largely by mental nurses. The individuals within the ward might be uncooperative in their treatment, a factor that could have added to the risks for the staff involved. This would certainly be so with regard to the handling of what was seen as possibly infectious material such as sputum. At the same time, for the patients effected, the possibility of release would be very unlikely under such circumstances where control and avoidance of extended risk would have been dealt with by physical containment.

In general, such events that would be examined formally today in the sense of "risk management" were then, from the evidence of the male nurse quoted above, seen as "part of the job". He experienced other incidents during his career, at least one of which was as serious as the incident in the padded room and involved a patient swinging a spade at his head during the supervision of a work party (Narrative evidence.) Although obviously shaken by these events at the time, he stayed in this employment for the rest of his career.

The incident in the padded room provides evidence of not only the difficulty of forcing individuals to do what they did not want to do, but also the level of frustration experienced by patients who, whilst disturbed, were being confined in such a way. In addition, the patient would have been placed in the room by the use

of force if he would not enter voluntarily. The term "chemical restraint" in this pre-war period meant only sedation, as no other forms of effective medication to deal with such events were available. An individual who was secluded might also have been sedated. There were strict rules governing observation and the monitoring of the physical condition of a patient in seclusion. There were also requirements regarding the opening of seclusion room doors for set periods during such an episode.

A further potential danger was that of fire. St Crispin Hospital had its own fire brigade with a full-time fire officer and male volunteers, mostly nurses. There was a fire engine and fire station to house it. A fire on one of the wards killed several patients late in the history of the hospital.

For patients, risk may relate not only to danger from staff, other patients and illness related factors but also to the problem of discrimination against those with a background of mental problems. As recalled by an ex-patient "M":

> *"... I... fought for my job in the Civil Service, while the Minister of Health was talking about re-absorbing the mentally ill back into the community, I was being kicked out because I had been diagnosed...and the reason that I was being kicked out was because I was being promoted into an established position in the Civil Service, and the Mandarins of the Civil Service wouldn't accept ex-psychiatrics because it would mean they'd have 300 extra people on their books, who as far as they were concerned, were a health risk, but they couldn't come up with the direct truth about this, so I was sacked... for confidential health reasons... I mean obviously it was because I was an ex-psychiatric, and that led to... to a news item on radio four... about the... man who'd been sacked... simply because he'd once been mentally ill and from that I got involved with MIND and... the, the trade unions, to fight to fight for the rights of people who had been psychiatrised."*

One major risk for patients was therefore that of difficulty in regaining what might have been considered a productive life in the conventional sense of the term. With

no alternative, the institution and area local to it, might have become the only available home. Outside the institution, except possibly within these outer boundaries of a geographic-occupational community, lay the possibility of prejudice and even physical dangers from a stigmatising of patients that might often have been deeply entrenched.

The data suggests that the very existence, physical structure, organisation and management of the old mental hospital was in itself a machine for controlling "risk" from inmates (see Chapter Four, pages 147 – 149), without the word being used in its modern constructed form. The notion of avoiding potential danger by the use of procedures to deal with crises, within a well staffed building with a high staff concentration to provide "back-up" are terms that might have been more familiar at the time. Up until the middle of the twentieth century, wards containing fifty inmates were not uncommon in many hospitals. Either minor violent incidents were dealt with on ordinary wards or, if necessary, patients were transferred to specialist "refractory" wards.

Those who were considered potentially suicidal or capable of harming others were put under various "levels" of observation. Such levels were determined by procedure committees and kept in procedure books (Archive material). The concern of risk, as already noted, led very often to ritualised and regimented practices in some wards. Also present was the danger of abusive behaviour towards patients. This occurred in some institutions and was the subject of public enquiries, as noted earlier (Nolan, 1993:135). A retired male nurse "C" speaking of the pre-war period at St Crispin

Hospital recalled the level of some of the, almost ritualistic, behaviour required by staff in minimising risk:

> *C. "There were incidents... I didn't I don't think that we thought, I can think of a couple of incidents in the fifty years I was sort of in the health service where I can remember one nurse getting stabbed and I can remember others being cut with a plate or whatever but you didn't... I don't think that you feared for your safety consciously, there were one or two hairy moments when people who were very difficult and you could get some powerful chaps who were known to be very difficult if they went over... kicked over the traces as it were but all the knives in the early days only just had a small cutting edge about two inches long in the knife and the fork in some wards had webbed, sort of webbed feet you know so you couldn't stick it in...the fork couldn't be used as a weapon and of course they were all counted meticulously and locked away in the knife box before the patients...the first thing that happened after a meal had been served in those days was that the, all the crockery...the cutlery was put in the sink washed up and everybody was busily drying up the...we were doing this ourselves to get the things through and counted and the patients were not allowed to get up from the dinner table until all the knives and forks and spoons all the cutlery had been counted and it was safely locked in the box."*

These practices tended to linger and have been argued to have contributed to the development of "institutionalisation" among many receiving care (Goffman, 1968). For example, to the knowledge of the author, the practice of cutlery counting mentioned in the above narrative extract, continued in a specialised male "disturbed" area, Dyson Ward, at St Crispin Hospital into the 1970s. A prime intention within these units was to contain and stop certain types of behaviour, for example violence or attempted suicide, from happening. Within a hospital generally, the degree of control could be effective.

(2) De-institutionalisation - the "Community of Interest", and the management of risk.

Although many in-patient units continue to be utilised, along with community based services, care, treatment and containment were, in the late 1970s beginning to speed up in their move away from the old main building at St Crispin Hospital. Nationally, many of the old institution buildings, including at St Crispin Hospital, have subsequently been closed and many knocked down or developed for other purposes including housing. Risk, as perceived in mental health services, was subsequently no longer managed within monolithic institutions where resources were concentrated in mainly one place.

With the prospective closure of the large institutions announced in the early 1960s, many staff sought new skills in rehabilitation training and followed the move towards community care. As already discovered, the old institutions often contained staff who were rooted in their localities in a way that sometimes included a number of generations. They also shared a common purpose of control, containment, care and treatment. These geographically based occupational communities, having declined in influence, were about to be displaced entirely by the development of a new approach, based on care outside of large institutions. This has been described as the "Community of Interest" in this research project.

Considerations of risk in mental health services shifted visibly to a broad geographic community, no longer concentrated among particular localised communities. Apart from large "special hospitals" such as Broadmoor, Rampton and Moss Side, dedicated in-patient units within the services now tend to contain a smaller number

of beds often numbered within the twenties and thirties. In some areas, with the closure of the old institutions, new facilities were developed in general hospitals, such as Addington Ward, the acute in-patient unit at Kettering. At Northampton, buildings on the periphery of the old institution, such as The Princess Marina Hospital and the Pendered Units are being used to this day. In Kettering, the grounds of what used to be the workhouse, St Mary's Hospital, had new units built within them to provide a rehabilitation unit and a psychiatric intensive care unit. The hospital also houses "in" and "out-patient" services for the elderly mentally ill. Such developments have had the effect of making the mental health services more publicly visible.

With the change of location and increased visibility, a difficulty was presented as to how to deal with issues of potential risk. Finding the best way to handle this issue involves problems. Scott (1998:309) comments:

> "Both maximising and minimising concern about the risk of mentally ill people being violent towards others may have damaging consequences. Maximising risk concern increases public fear, leading to greater stigmatisation and avoidance of the mentally ill. As a result, patients may experience increased stress which, in turn, increases the risk of relapse into psychosis, and thus brings about a self-fulfilling prophesy as argued above. Defensive practices by professionals may lead to periods of detention which are longer, and in more secure conditions, than would otherwise have been judged necessary.
> Minimisation may have positive advantages for the individual, reducing the damaging consequences of labelling, limiting the iatrogenic effects of medication and institutional care and increasing autonomy. However, if an optimum balance between autonomy and need for the support and supervision necessary to maintain recovery is not achieved, these strategies may increase the risk of patient violence both to others and themselves."

The difficulties in balancing these factors are obvious. Get it wrong and the consequences could be potentially serious. In exploring failure of community care as highlighted by mental health inquiries focussing on murders by mentally ill

individuals, Kemshall (2002:98) comments, "These reports attracted greater media attention and public disquiet than their predecessors which had focussed on the abuse of patients in psychiatric institutions." The perception of danger by the general public can arguably be said to derive partly from the fact that violence (and the murder rate) by the mentally ill may not have gone up appreciably but they are now more conscious of it, being outside and among them. Such events are well publicised by today's very effective mass media.

The placing of services within a broad spread of residential areas placed individuals, many of whom may have been in mental hospitals for many years, among populations who may initially have been unused to the notion (if not the fact) of mixing with those identified as mentally ill. These services included early on the "day hospitals", which were established between the late 1940s and 1960s. We have already seen (Chapter One) that outpatient clinics were encouraged after the Mental Treatment Act of 1930. Jones (1972:283) comments:

> "Out-patient clinics were the first attempt to break away from the concept of the institution as the only means of treatment apart from charity or the Poor Law. After 1948, local authority care, day and night hospitals, sheltered workshops and other experimental forms of care did much to break down the old distinction between being totally well (at home) and totally sick (in hospital). Britain began to attempt the provision of a flexible range of services to meet the varying needs of individuals."

These developments have taken place relatively gradually, before the closure of the large hospitals. Within the earlier mental health occupational communities, much of the care of in-patients took place on a relatively large scale, and in an enclosed environment. As noted, limited and strictly controlled, opportunities for public scrutiny and therefore potential anxiety were ensured.

The economy of scale in managing risk presented by a large, concentrated work force therefore no longer exists in contemporary mental health services. The move to a community-based service has had other consequences. In instituting this new service, a loss of life skills for independent living was lacking among many patients, particularly long-stay patients. This had been caused largely by the bureaucratisation of the care of large numbers of individuals within institutions that may have made the controlling of risk for staff and public easier, or at least helped to manage the subjective sense of risk, but at the cost of depersonalising many patients.

After the Second World War, with the rise in car ownership in particular, a hospital workforce no longer needed to live locally, within the type of "Geographic-Occupational Community" described in Chapter Four. The geographical mobility of the workforce was eventually to make feasible the community based service itself, just as such mobility had originally induced change to the original locality-based nature of the earlier service.

McCourt Perring (1993:29) discusses the conceptual and practical basis of the move to community care. She identifies several aspects that appear in opposition. On the one hand, a more "secure basis" for psychiatry within medicine is identified. McCourt Perring cites Jones (1972) as seeing the move as "linear" and progressive, whereby developments in medicine have allowed social care and medical care to return to their correct places. The role of the in-patients facilities becomes "treatment and rehabilitation rather than care and control". Foucault (1967) is cited as seeing the development of community care reflecting "madness long since mastered". This focuses on a time when asylums, later mental hospitals, up until at

least the middle of the last century, had limited effective treatment regimes and placed emphasis on care, control and containment. McCourt Perring (1993:29) also contrasts the question of Jones (1972) as to why early moves to reform were not realised, with the assertions of Skull (1979) and Foucault (1967), that the development of the asylums was related to "concepts of order rather than medicine, arising as one of the answers to broad economic change and crisis." Issues of adequate care and control, although linked closely to medical developments, such as effective depot drugs, would be tempered also by continuing legislation and policy development. These affect the workings of a now predominately community-based service and often occur in response to events. Some of these recent issues will be considered later in this chapter.

There are extensive extant texts on the move from institutional care to community. Included in these works are the following; Butler (1993) relates the political background to strategic initiatives and policy development in mental health services. In discussing the emergence of Care Management, Case Management and the Care Programme Approach as policies, Butler (1993:99) refers to the "six functions which are: defining the client, assessment, developing the care plan, introducing packages of care, provision of a direct service and monitoring and review". Butler notes that in only case management is a single named person involved from the beginning to the end in assessment and review. As well as being an "enabler", the case manager has also to find a balance between the "patient's/clients risk, entitlement and dependency and the personal responsibility of the case manager" (Butler, 1993:101). These developments are a clear reflection of the changes that have developed in the systems of community-based mental health provision where previously all of these

considerations were hospital-based in policies towards ward-based groups of patients. Risk estimation in particular was linked to the general administration of a ward, where particular individuals would be placed on specific levels of observation, as already noted, but the main emphasis was on the management of a group rather than the individual. Named "key worker" and "case manager" systems place the focus of responsibility much more on the individual professional in a multidisciplinary organisation. Risk assessment and management in its literal older sense was previously the responsibility of teams of nurses and doctors within a closed physical environment. Standard policies approved by hospital procedure committees were applied blanket fashion to all and updated as was felt necessary.

In what is an anthropological study, McCourt Perring (1993) focuses in particular on patients experiencing the closure of the institutions Friern and Claybury and the utilisation of group homes. It is noted that of the early residents of this form of accommodation studied, they were "typical of the long-stay population of the hospital." (McCourt Perring, 1993:47), These individuals were willing to leave hospital and were considered less dependent than those who would "be re-housed by the statutory authorities." As such, they could also be considered to provide lower levels of risk. There is an increasing tendency of psychiatry to involve itself in increasing areas of life and particularly with respect to the identification of social deviancy as mental illness. Comment is made by McCourt Perring (1993:33) of the fear or possibility of mental health workers "losing control" and notes that:

> "The period has also been one of expansion by psychiatry into increasing areas of life, increasingly defining social deviancy as mental illness (Conrad 1981) and emphasising control of symptoms (Brown 1985) an emphasis which has carried over into non medical community care facilities."

To conduct care and retain control and therefore reduce potential risk, within a broad geographic area requires bureaucratic efficiency with a good level of co-operation between different agencies the need for which was stressed in The Griffiths Report (1988). The awareness that things may go wrong, particularly if a possible result is a highly publicised tragedy, is a strong motivating force for caution and can induce nervousness on the part of care workers. Although some element of risk is unavoidable if an individual is to be helped to take back some responsibility for his/her own life, the modern pressure is concentrated on eliminating all risk. Failure may be seen as being systemic and organisational, for example with respect to policy or of resource allocation. It may also be because of a perception of neglect by a key professional individual or individuals. Problems identified as neglect can have serious consequences for the careers of individual workers and not just those on the lower rungs of a professional ladder. The implications of these problems will be discussed later in this chapter when risk management in modern society is explored.

Jack (1998:44) considers community care as opposed to institutional care and challenges some conventional wisdom by emphasising the value of aspects of residential as opposed to non-residential care. In discussing the closure of psychiatric hospitals, however, he focuses on a problem at Friern Hospital of the "difficult to place" patient. This group is identified as relatively young and in the majority male. A characteristic is a slightly more disturbed mental state but with the distinctive feature "associated with disruptive modes of behaviour" These could include physical and verbal aggression, non-compliance with treatment and inappropriate behaviour of a sexual nature. These individuals are recognised by Jack as the new "long stay" patients who are not always manageable outside the setting of

a psychiatric facility. Many may periodically be transferred to Intensive Care Units within new small-scale (compared to the old institutions) in-patient facilities. Their continued presence there will be seen as blocking beds however. "Hostel wards" described as "wards in a house" are a solution put forward by Jack but the risks provided by these individuals are often dealt with by service providers buying places at specialist units, sometimes within private institutions such as St Andrew's Hospital in Northampton. Sometimes individuals who leave may reappear via the criminal justice system.

Ramon (1992:93) explores the process of hospital closure, followed by the development of an appropriate strategy and adequate new services. Ramon acknowledges that the "risk-taking elements in mental health are always present." He also argues however that in

> "...part the attraction in mental health work is that of dealing with the partially unknown, of risking to an extent one's own sanity and not only that of one's client, of moving in and out of psychologically threatening territories."

However added to this, must now be a consideration for organisations of the risk of sickness and absenteeism among staff or even litigation by those unable to deal with the stresses of work. The latter is a particular danger if support mechanisms are not felt to exist.

In citing defence mechanisms, recorded in table form, among student nurses in a general hospital by Menzies-Lyth (1988), Ramon (1992:89) argues that they are more typical of hospital workers than community workers. Many display the ability of being able to "hide" within a hierarchical task and group based organisation. This is at variance with community work where such manoeuvres are not as feasible.

Work setting and support structures are however acknowledged as important in how professionals respond to clients and presumably deal with their own problems. The issue of the availability of the support of smaller unit, or hospital based, and therefore geographically based, in-patient support systems for a community-based service is an important characteristic of the "Community of Risk" in mental health. A lone community psychiatric nurse or social worker, although having ostensibly the support of a multidisciplinary team, has the responsibility of sometimes managing acute situations in a comparatively isolated setting without the immediate support of other members of an occupational community as present in a hospital. Attendant on this is also the fear of error where it is impossible to use such strategies as for example to "hide" in a setting of "collusive social redistribution of responsibility and irresponsibility" as defined by Menzies-Lyth (Ramon 1992:90). In-patient facilities, although now not generally based in large buildings, provide an important backup in acute situations and can be seen as part of a community based service.

Within the "Geographic-occupational Community" of a hospital like St Crispin, decision making at ward level would be based on a hierarchical system. As we have seen, a Charge Nurse or Ward Sister stood at the pinnacle. Authority devolved down through the layers of staff below with levels of ultimate responsibility clearly defined by a qualification-based position within the group. Many interactions with individual patients took place, of course, on a personal level, but always theoretically under the scrutiny of the nurse in charge who had ultimate responsibility. There was also always the option of consultation with a doctor or more senior nurse if it was felt a situation warranted this.

It was also important, within such a hierarchical setting, for a feeling of personal security and support within the group, to have a good relationship with a Charge Nurse or Ward Sister. A male nurse who worked as a student on the Pendereds recalled:

> *"It was..I think if you were accepted it was a ..a good and close relationship.)You know I.. 'cause I 'll always remember this I me..I always can remember ...certainly the Deputy Charge Nurse on..on the Pendered East ..if he liked you, you were in, you were Ok, you were fine...Unfortunately they..you know, I ..I was liked. What happened to the people who weren't liked I have no idea.."*

The nature of individual feelings of acceptance and perhaps security for staff could therefore, in some cases, be seen as starting at a personal level with being welcomed or rejected within the hierarchical structure of the ward. The ward organisation under the Charge Nurse or Ward Sister provided the basic unit of collective responsibility and at a higher level was the hospital organisation with its structural design to support control and contain with human resources available to provide rapid supportive reactions to crises. This system provided a formidable system of control and the facilities to manage perceived risk within the enclosed area of the institution. The nature of responsibility, although there could still be individual error, was therefore spread through a diverse and large group of individuals with clearly defined levels of authority.

With the development of community care, the support mechanisms inherent for staff working in a geographic-occupational setting have not been present for those working outside. Under such circumstances with the level of responsibility becoming more personal than collective and more public than geographically enclosed there could understandably be some avoidance of risk. This could, for example, be reflected in rising admission rates to dedicated in-patient units where

more systematised and traditional methods might remain. Donald, Lancaster and Forster (2001:16) acknowledge risk assessment to be an "inexact science" in which different practitioners "will have their own threshold at which risk will be regarded as a problem". In addition, practitioners apart, Scott (1998:309-310) comments, "Professionals and family carers appear, sometimes, to have different priorities with respect to risk management".

The position of the family of a patient during the days of institution based care was that of a visitor during set times of the week. At St Crispin Hospital during the 1930s this may even have been within a dedicated room that the patient would be escorted to, having been smartened up for the visit (Research Notebooks: 6/10/99). If a patient was at home on leave, any crisis would usually be dealt with by a rapid return to hospital. The involvement of carers, whether relatives or others, has added a new dimension in that their direct involvement in the planning process may now be required. The total control within the large institution now having been removed, circumstances where the actions of staff would be unquestioned have therefore gone. Added to this has been the opening up of the institutions to volunteers and others with the development of the community of interest discussed in Chapter Five. The influence of "consumerism", where services and service providers can be questioned and their decisions challenged can be argued to have altered attitudes that enabled the secret world of the monolithic old hospitals to continue.

Also, in circumstances where the knowledge of dangerous incidents could, to a degree, sometimes be "hidden" within a set geographic community, as noted above, there was perhaps not such a problem for the staff individuals concerned. Now, with

the crises often occurring publicly, within general areas of population, acceptance of varying "personal thresholds" can arguably no longer be seen as acceptable. Responsibility, it can be argued was spread with the use of ever more complex and specific guidelines. In this way, incorrect or inadequate policies could be seen as at fault rather than individual error. This would also have the effect of passing responsibility up the chain of command rather than down. The comment, "this must never be allowed to happen again" is often accompanied, after a trial or enquiry, with recommendations for policy or protocol changes to be implemented. The tendency could be said to be towards aiming to reduce risk to a minimum or even eliminating it altogether, an altogether impossible perspective.

Beck (1992:4), in a more general sense, comments on risk from technological or other processes and throws light on the overall nature of this problem also:

> "First such physical risks are always are always created and effected in social systems, for example by organisations and institutions which are supposed to manage and control the risky activity. Second, the magnitude of the physical risks is therefore a direct function of the quality of social relationships and processes. Third, the primary risk, even for the most technically intensive activities (indeed perhaps most especially for them), is that of social dependency upon institutions and actors who may well be – and arguably are increasingly – alien, obscure and inaccessible to most people affected by the risks in question."

Although this comment applies to technical processes, it could arguably be applied to problems in mental health and social services. Comments about breakdowns in communication between individuals and/or services, failure to follow policies and the requirements of operational confidentiality or even secrecy may be cited when problems occur. Such hypothetical individual failings, it can be argued, would tend to pass responsibility more down the chain of command, and become a source of anxiety to the actors involved.

Among strategies that determine effective services and therefore minimise risk, the importance of continuity is emphasised by Allsop (1984:101-2) in describing policies for community care. Criticisms are noted of community care that took place in the 1980s in particular.

In Northamptonshire in the early 1980s, the service previously supplied solely by St Crispin Hospital was divided between the north of the county and the south into what were effectively two separate services. In the north, acute in-patient services were based within an admission unit at Kettering General Hospital. This replaced the old acute admission facilities for the north that had originally been within the institution. In the south they remained based in newer peripheral buildings on the site of the old hospital. Services for the elderly, who originated from the north, were also moved largely to sites in the north of the county. For a time, until a new unit was built, along with a rehabilitation facility, at St Mary's Hospital in Kettering, Intensive Care facilities for the northern service remained within the old institution.

Although there were some concerns periodically about risks to safety from general staff at Kettering District General Hospital, now hosting the acute psychiatric facility, overall the relationship between the two disciplines was relatively good. Mental health staff provided advice and support during incidences of threatened or actual violence (not necessarily by possible mental health patients), towards general staff within areas such as accident and emergency, and ran a rapid self-harm assessment service. In-patients from the psychiatric unit, who were allowed out, shared the shop, hairdressing and other facilities with general hospital patients.

Nonetheless, the fear of violence reflected in the behaviour of the occasional patient was never far from the surface. On the other hand, the unit generally compared favourably to the "Accident and Emergency Department", in this respect, to the knowledge of the author. This general hospital based service was linked by community teams to day hospitals and other resource centres in the north of the county.

For those in the south of the county at this time, the situation was somewhat different. In-patients services as well as nurse training and other facilities were still based at St Crispin. Although there were day hospitals and community psychiatric nurses in the south of the county, some worked to a different system than in the north, being linked to GP practices rather than all as members of community teams. Although general Department of Health guidelines may have been followed, services, as in other areas, developed different strategies for implementation. However, both were destined later to come together in another reorganisation of health care trusts rather than maintain continuity as separate services. This sequence of developments represented the final break-up of the original St Crispin Hospital centred service and the institutional model of risk management. Services have since come to embrace formal risk assessment procedures not only as part of an initial assessment but throughout an episode of contact. A further characteristic of modern risk management is the increased emphasis given to specialised training. Staff are discouraged from participating in activities they have not been formally prepared for. Failure to follow such protocols could, in extreme cases result in disciplinary action or effect possible compensation payments. A key policy in this respect could be that relating to training for "control and restraint" techniques.

Risk assessment policies operated by Northamptonshire Community Healthcare Trust, the current mental health service provider in the county, will be examined in more detail later in this chapter.

Risk and the discharged patient.

Risk for a current patient group and those with a history of mental illness, is an important issue. The personal experiences of a group of individuals, who have a history of schizophrenia, in the move to community care, are provided in narrative form by Barham and Hayward (1991). The assessment of risk is not discussed as a specific policy issue but the difficulties of individuals potentially at risk are explored from their own perspective. Among factors governing potential problems for ex-mental patients were those of "disconnection and structural isolation" as well as the potential for poverty in poor accommodation. Added to this could also be the danger of homelessness and the loss of contact with supporting services. In what could be related or contribute to stigma about mental illness, Barham and Hayward (1991:135) identify a difficulty to "surmount an identity as a mental patient. Even where participants might be said to have 'got better' their credibility was easily put in question." Managing without support was seen as "a high risk enterprise."

Barham (1992:54) explores risk from the perspective of individual ex-patients during the closure of the old mental hospitals. A significant risk identified by Barham for those with a history of mental illness is that of homelessness. In the case of institutionalised care, the individual who was mentally ill, or significantly had been mentally ill, they simply remained in hospital leading to the development of a large population of "institutionalised" patients.

> "A significant worry for many people is that if they experience a relapse they will find themselves pitched back to square one, as Simon put it. Not infrequently, 'square one' means a return to homelessness."

The closure of institutions and the subsequent potential decline of "asylum" is explored in the context of how it can continue to be developed in community care by Tomlinson, Carrier and Oerton (1996). The notion of a place of asylum and safety can be interpreted as important in dealing with situations that can result in risk, whether it be to the individual concerned with a risk of self-harm or neglect or danger to another. Risk management is not explored directly by Wallcraft (1996:198) but crisis intervention schemes that deal with immediate risk are discussed. Two examples given are of:

(1) " The mainstream psychiatric service"

This is more traditional with early intervention, removal to a "place of safety" that may be under section or voluntary and rapid commencement of medication. This is seen as convenient, but open to abuse such as in the high usage of Section 136 on young black males and the number of deaths from overmedication.

(2) "Crisis intervention services and crisis houses"

An example is used of the crisis team based at Napsbury Hospital that consisted of a psychiatrist, a nurse and a social worker. The approach, influenced by the work of Dr R. D. Laing, consisted of a fast intervention within the patient's own home involving a process of talking through a crisis. Other services such as marital therapy or general family therapy may be offered after this initial intervention and assessment. Medication may be used in such situations as sleep deprivation but not as a primary treatment. In another instance such as that at the Arbours Centre in North London, individuals in crisis are "guested" during the period of their crisis.

The development of these services compared to the mainstream approach indicates that dealing with risk is a key conceptual resource for managing people with mental illness. In the northern Northamptonshire services, a multidisciplinary "Rapid Resolution Home Treatment Team" was founded to perform similar services to earlier national initiatives. Services in the north were mirrored in the south after the unifying of the two ends of the county under the one Northamptonshire Community Healthcare Trust. Serious risk situations would usually be dealt with by admission to short-stay in-patient units. From there an individual, if not discharged after what was felt to be an appropriate period because of, for example, homelessness might be moved on to a "sub-acute" in-patient unit.

The move to community care in Exeter is described by King (1991). Although the description of the service development is detailed, there is no mention of any risk evaluation or risk strategy considered prior or during the development of new services. However, obstruction in the obtaining of planning permission for outside units during periods of consultation is referred to. In meetings with potential neighbours with:

> "...a few rare and blessed exceptions they have been opportunities for an endless parade of all the customary concerns and prejudices: fears of physical violence and sexual impropriety, laced with an underlying concern about diminishing property values." (King (1991:65)

The fact that perceived potential problems of risk had previously been seen as contained within the walls of institutions, linked to stigma within broader communities towards mental illness, led to a requirement for much consultation and diplomacy in introducing new units. This contrasted with the more tolerant attitude

towards mental patients within the occupational communities explored in chapters four and five.

There is specific mention of risk management by Payne (1999:254) in a history of care in the community. Problems that can be identified as potentially creating risks, such as a lack of adequate after-care services and difficulties with the introduction of care-management, are highlighted. Attempted solutions to the crisis in community care from the late 1980s and early 1990s included Department of Health guidelines that led to the introduction of "at risk" registers and supervision registers for patients. In discussion on the aftermath of one particular case that will be further discussed, Payne (1999:263) makes the point that:

> "Whilst there were high-profile cases such as that of Clunis featuring random acts of violence against the public, the vast majority of acts of violence are committed by those who are not diagnosed as mentally ill. The most significant risk for those suffering from mental illness is the risk of suicide and self-harm and risks of violence against them by members of the public."

The Clunis case will be re-visited later in this chapter. One of the strategies devised within the mental health services to deal with these problems from first contact with potential patients is that of "risk management". This will be examined next.

(3) Risk management in modern mental health services – the "Community of Risk".

(a) Risk Management.

Risk estimation and policies of risk management, in respect of society generally, has become the norm. Today, the mental health service has changed in line with these broader social developments. A typical strategy of risk identification in mental

health and associated services is that of south-west London and St George's Mental Health NHS Trust. The management of potential risk is defined in the following way:

> "Risk management is the process of systematically identifying risks, analysing the likelihood and impact of their occurrence, and then deciding what action to take to prevent, minimise, accept or transfer these risks in a way that will enable the Trust to minimise losses and maximise opportunities.' (Copyright South West London and St George's Mental Health NHS Trust Governance Committee, 2004:3)

The failure of any NHS Trust to have adequate up-to-date and appropriate risk assessment and risk management policies is itself to take a risk with the potential threat of litigation and public criticism and opprobrium. Significantly, Thomas (1997:202), in discussing risk management in in-patient care, states:

> "Mental health care is a risk activity. In-patient units exist to assess and treat people with mental illness and, to keep them safe, as well as to relieve symptoms. Every effort must be made to ensure that people who are admitted to in-patient wards, staff and members of the public come to no harm as a result of their contacts with the service. Evaluation of an in-patient setting also involves the assessment of risk. Risks are usually related to situations that could result in legal action involving patients, families, the hospital or the health care provider."

The requirements of risk assessment apply equally to outpatient and community care also. In Northamptonshire, it is policy that a risk assessment strategy using "ePEX-3", a configurable, multi-disciplinary care planning programme, devised by "Protechnic", is utilised during contact with potential patients. This takes place from a first assessment onwards. The risk assessment policy at a mental health service today may be seen as typified by that of The Northamptonshire Community Healthcare Trust. In 1990 the Department of Health introduced the "Care Programme Approach". This system is designed to work with each individual patient who is continuously assessed providing a care plan developed by a "key worker". Key workers were, in in-patient settings, initially usually nurses. The care plan then,

in theory followed the patient through the progress of their involvement with the services.

Problems leading to tragedies (and therefore sometimes enquiries), were often blamed on breakdowns in communication. In Northamptonshire, "risk assessment" is stringently carried out from the first point of contact with a potential client (Northamptonshire Community Healthcare Trust Protocols). It is incorporated into a "Care Programme Approach" (CPA) module based on the "ePEX-3" electronic records system, as noted. The assessment takes place over two stages. First, a "risk screening" is carried out followed as early as possible by a full "multidisciplinary risk assessment". An assessment is also repeated on the movement of clients, not only from the community to hospital and back, but also from in-patient unit to in-patient unit. In addition, the training of staff in risk assessment policies and practice is mandatory. The move away from the management of risk by containment within and around designated areas of a geographically placed institution has involved the development of policy and procedure governing all aspects of care and scrutiny. The assessment of risk can now be argued to be of primary governance in mental health provision. It is the also the first "need" estimated.

Admission periods to the new and smaller in-patient units are much shorter generally (outside the special hospitals) compared to the days of "certification" where admission periods covering decades may not have been uncommon. However, a group of individuals in the past described as "revolving door" patients are still constantly being re-admitted to the services. Many have long-term involvement with

outpatient clinics, primary care services, community psychiatric nurses, social workers and/or non-statutory supportive services such as MIND.

Although what would now be termed risk assessment took place on admission (and after) within institutions up to the middle of the twentieth century, the constant assessment of risk and its recording characterises, in particular, contemporary regimes in mental health.

The management of risk might once have been based on containment and observation within a specific, purpose designed, architecture (for example, walls, locked doors, and seclusion facilities) and institutional (staff with keys and the counting of cutlery after each meal) whereas now it is much more to do with protocols assessments, decision making and key workers, allied to the growing field of information technology.

Although those receiving treatment for mental illness, at some point within their lives, constitute a fairly large proportion of the population, some for example with psychotic conditions, like schizophrenia, may tend, as noted, to be more open to public gaze during times when their conditions are particularly florid. The breaking down of the hypothetically generally more tolerant old geographical-occupational communities has already been alluded to. In addition, the type of incident that may have once have been contained within the old hospital walls has in the recent past moved into a much more visible public arena. Some events involving those identified as mentally ill or who have been refused admission as inappropriate, or

perceived to be mismanaged, has affected public concern (Payne, 1999:244). Two such events will be considered next.

(a) The anticipation of risk.

Jonathan Zito died after an unprovoked attack while he waited for a Tube train at Finsbury Park station in north London in 1992. His killer, Christopher Clunis, had been released from hospital under the care in the community programme. Another incident, the seemingly motiveless murder of Lin Russell, her daughter Megan and the attempted murder of Megan's sister Josie in Chillenden near Canterbury in 1996 was used to reinforce calls for changes in mental health law. Such events have received wide publicity. Suicide and attempted suicide, particularly (currently) among young males has been the subject of considerable media exposure. Events like the Russell and Zito murders, it can be argued, increase the awareness of potential risk in respect of mental health. This, it can be argued, extends across all sections of society including the media, the general public, in mental health workers, in mental health service managers and in politicians. These events have also prompted calls for legislative change in order to increase control of one group in particular who are often considered untreatable by psychiatrists. This group is defined as those with "dangerous severe personality disorders".

Changes to the current Mental Health Act of 1983 were proposed by the United Kingdom's New Labour government in 2002. The Bill was withdrawn after criticism from more than sixty professional bodies and charities. This included concerns, known to the author, expressed in a meeting with local Members of Parliament by Associate Managers for Mental Health Act Appeals in Northamptonshire. Some

aspects related to the areas of human rights and civil liberties. One concern related to proposals to legalise detention of those with "dangerous severe personality disorder" (DSPD) who have not committed a crime. Of particular concern was the blurring of roles between mental health services and the provisions of the criminal justice system. Psychiatrists have objected to being placed in a policing role. There is also the danger that psychiatrists might be placed under pressure to order the compulsory treatment of people who could possibly pose a risk, in case later they were held to account for failing to act. The potential risk from such an individual was felt by the government to justify intervention, as in the cases already alluded to of the murders of Lin and Megan Russell.

In addition, another measure, the proposed removal of hospital managers from the appeal process, would have left those formally detained with an opportunity to appeal just once during their stay to a tribunal. Currently, patients can appeal to hospital managers as often as they feel is necessary. It was also proposed that the "approved" social worker role should be dropped. The question has remained as to how far such events could be anticipated and the extent of the steps necessary to prevent them. A replacement Bill published in September 2004 was also denounced on human rights grounds.

Other recent developments are linked also to the use of electronic record keeping and the easier availability of information. Potential implications resulting from technological change are shown in the case of the Soham murders (the murder on 4th August 2002 of two schoolgirls, Holly Wells and Jessica Chapman, by a caretaker, Ian Huntley, employed at their school). After his arrest, it was found that allegations of numerous previous sexual assaults against young girls by Huntley had either not

been entered or cleared from police files. The subsequent criticism of the police service implied that some part of the blame for the tragedy was related to a failure by two areas of administration to first adequately record and retain information and second to have efficient systems to share it. The outcome of the Soham trial also led to calls for the government to clarify urgently how the Data Protection Act should be applied and interpreted by those agencies responsible for public protection.

The on-line updates of the Mental Health Foundation include "The Multi-agency Management of Sex Offenders in the Community" (2004: Updates: Volume 2, Issue 1). The further bureaucratisation of risk assessment and increased surveillance with the use of information technology seems to be becoming a very strong trend in mental health and is a strong identifying factor of the "Community of Risk." The walls of the asylum and the localised nature of the care community are replaced by more intense and comprehensive, if more distanced, surveillance and information exchange systems as implied for the police service following Soham

In discussing the term "de-routinisation" in exploring social change in industrialised societies, Giddens (1979:220) states that it refers to

> "...any influence that acts to counter the grip of the taken for granted character of day to day interaction. Routine is closely linked to tradition in the sense that tradition 'underwrites' the continuity of practices in the elapsing of time. Any influences which corrode or place in question traditional practices carry with them the likelihood of accelerating change."

Traditional practices based within and around the institutions in the management of the mentally ill have been replaced by a community-based service. In response to the process of "de-traditionalisation", increasing numbers of policy and legislative initiatives devised to manage risk in mental health are devised. Such policy and

legislation change is outlined by Kemshall (2002:99-110). The development of processes to achieve a reflexive scrutiny of the client and the mental health professional appears to be increasing.

The Mental Health Foundation numbers a very broad categorisation of areas of interest in the field of mental health problems. This includes: self harm, violence and aggression (including bullying of those with "disabilities"), suicide and substance abuse (including nicotine). A broadening of the areas of interest of psychiatry and mental health services has developed since The Mental Treatment Act of 1930 first encouraged the admission of those with "neurotic" as opposed solely to "psychotic" conditions as voluntary patients. This tendency may be identified as increasing the role of psychiatry in new areas of social control.

The role of training in "control and restraint" techniques has already been alluded to. In new policy initiatives it is ongoing as opposed to an earlier period such as the 1930s when nurses, for example, may have taken no further qualification after their final examination as students. It is now also broader and includes all areas of involvement including among volunteers. All are now involved in risk estimation. The Mental Health Foundation in, MHF Briefing Number 9 (1997), comments that The Newby Inquiry in 1995 "identified the importance of training for working in community mental health projects (those) who did not come from a professional mental health background. This included volunteers." Core skills and attitudes required include that:

> "Staff should demonstrate foundation skills in:
> *Effective communication.
> * Recognising and supporting service users' own coping strategies.
> * Working as part of a multi-agency team, including partnerships with service users.

* Establishing, sustaining, disengaging and re-establishing working relationships with service users.
* Assessment of risks to, or of, the service user, including hazards posed by environmental constraints (e.g. group or shared living).
* The prevention and management of behaviour which is dangerous to self and others."

The Newby Inquiry report listed requirements for training. The indications are that controlling risk is felt to relate in part to increased professionalisation and education among all.

(4) Conclusion.

The management of risk has always been a part of the history of mental health services. The very incarceration of those whom we now call mentally ill was part of the broader incarceration of the disparate body of the mob, the unemployed, the mentally ill, the paupers and so on, who were not readily subject to the disciplines of new industrial working practices and who left unchecked were perceived as a risk to the emerging social order. The practice of locked doors and concealed communities within the "Geographic-occupational Community" is also testimony to the fact that risk as an organising feature of mental health governance is not new in the latter half of the twentieth and early part of the twenty-first centuries.

Likewise, during the post-war "Community of Interest", the notion of risk was becoming increasingly apparent. The unlocking of doors by the charismatic medical superintendent did not sit easily with many staff who found the security of their routinised work practices threatened by such actions. Even the new emphasis on normalisation of the patient's day, that formed part of the community of interest, was at times tentative and hedged around with strategies for minimising risk. In this way, patients were indeed taken shopping for their new individualised wardrobe of

clothes, but visits into town were supervised, sometimes to reduce the risk of disturbing the boundaries of polite social behaviour.

It is just that towards the end of the twentieth century, risk becomes an almost all-encompassing mode of governance. The very first activity in admitting a patient is now a thorough risk assessment, for possible harm to themselves, and for harm to others whether other patients, staff or members of the general public. As is the case in the field of crime (and topically of terrorism) the focus becomes not only on those who are mentally ill, but on those who are potentially dangerous in the absence of any expressed or overt actions to that effect. When outright incarceration sits uneasily within a society that expresses a commitment to "human rights", the modes of governance have to become subtler, but arguably even more hidden from external and independent scrutiny. Being physically located in a geographic-occupational community provides a physical space with which one can be identified, and against which one can therefore protest. Being part of a community of interest could in one sense be regarded as a brake on unchecked authority. But being subject to the community of risk, to a mode of governance that does not depend upon one's actions, but upon the actions imputed to one by others, is an especially difficult mode of governance to resist.

This chapter has explored the progression and concept of the "Community of Risk", in mental health, as a means of understanding current developments in social, legislative and legal aspects effecting mental health services. The origins of elements of the "Community of Risk" in mental health have sometimes appeared as bureaucratic responses to difficulties identified as the new service has developed.

They also reflect wider social change in respect of the attempted controlling of risk. The results of the chapter link with the identification of earlier theoretical definitions of community that have been explored in a historical context. This chapter has identified the genesis of the concept of communities of risk in the period when geographic-occupational communities were strong. At this earlier stage, however, deviance types of risk (behaving strangely but inoffensively) could be tolerated because the characters were known to a work and local community who were nearly co-terminous. The way in which potentially dangerous types of risk (physical violence to self and others) could be managed by observations, checking and direct interventions was made possible by the concentration of staff within the walls of a hospital has been explored. The fact there were also risks for patients in sometimes-regimented environments where physical restraint was not uncommon has been considered. The fact that staff-adjudged patient deviance could also later be contained with the increasing use of drugs by medical staff has been noted.

The way the real "Community of Risk" discourse comes into play with care in the community has been revealed. The chapter has also discussed the way general deviance type risk is to be managed through a broad range of treatment initiatives and education within community services supported by relatively small in-patient facilities. Violent risk is to be managed by protocols with tracking and possible anti-civil liberties legislation permitting pre-emptive action to curtail even suspected potential dangers. Risk in the context of de-institutionalisation, with the loosening of the support and control provided by the old "Geographic-Occupational Community", leading to tighter regulation has also been explored. This has been followed by an

examination of risk management in the modern mental health services. Some of the influences driving change have been explored.

CHAPTER SEVEN

CONCEPTS OF COMMUNITY AND THE HISTORY OF MENTAL HEALTH SERVICES REVISITED

Introduction.

This chapter will summarise what has been discovered in the research, in regard to questions arising from the literature search and pilot study, of concepts of community in mental health between approximately 1935 and 1965. The research has drawn upon data from a number of sources but has focused in particular on services within, and emanating from, St Crispin Hospital in Northampton. Data has been drawn from an earlier research project with the aim of exploring, in more depth, questions that were raised in that project and left unanswered. This applies in particular to the nature of the relationships between the hospital and local people of Duston within which St Crispin Hospital was placed for over one hundred years.

A multi-strategy, modified grounded theory research methodology has been developed to explore factors shaping evolving concepts of the nature of community, primarily in relation to that hospital. That methodology has involved, along with extant literature, film and archive material analysis, of data that has included interviews with members of the following groups;

- Nursing Staff.
- Medical Staff.
- Ancillary Staff.
- Volunteer groups.

- Other individuals who were witness to aspects of the operation of the mental hospital as an institution during its heyday.
- Patient "voices" were obtained by proxy, based on similar ex-patient groups, because of concern at the lack of local representation from St Crispin Hospital. This enabled a degree of checking that was acknowledged as limited, from the perspective of this group, of the analytical concepts developed.

The research has developed an original theoretical perspective in understanding the origin, evolution and nature of concepts of community in relation to mental health during the "watershed" period of 1935 to 1965. A rationale for an exploration of that particular time-span has been presented. The background of the author in mental health is acknowledged and the implications of this are discussed.

The results of the research are presented next as follows:

Chapter Four and Chapter Five relate the results of two periods in respect of mental health services. Chapter Four explores the period between 1935 and 1950 and Chapter Five, the period between 1950 and 1965. The changes that took place during these two periods are not demonstrated to be distinctly separate in a mechanical sense, but to be phases in a progression. However, there is evidence of a particular hiatus during the Second World War, and of significant reforming developments from the early 1950s onwards. Chapter Six explores the concept of "Communities of Risk" applied to mental health and brings the study up to the present time.

The first part of this chapter will concentrate on the results relating to the traditional hospital that existed until the development of community care policies. The second part will explore developments since and their origins from within the original

service. The results will be presented in relation to the literature searches in chapters one and two. They will be outlined in the same order as in the results chapters four, five and six as follows:

- Part One (Chapter Four - Voices on mental health communities 1935 – 1950: The "Geographic-occupational Community".)

- Part Two (Chapter Five - Voices on mental health communities 1950 – 1965: The Demise of the "Geographic-occupational Community" and origins of the "Community of Interest".)

- Part Three (Chapter Six: The "Community of Risk".)

Part One: Voices on mental health communities 1935 – 1950: The "Geographic-occupational Community".

The evidence in Chapter Four reveals that mental hospitals during the early part of the twentieth century were complex hierarchical social structures governed largely by rules and protocol. The results are similar to previous findings in being supportive of existing published material, for example, Goffman (1968), (Scull. (1979) and Gittins (1998). Hierarchy extended not only among staff but also in particular ways among patients. All aspects of a patient's life are revealed as being governed. This even extended to clothing that was issued from a general store. Staff were uniformed. Many patients were managed firmly, and governed in a way that sometimes included seclusion and physical restraint. Medical treatments are revealed at this time as being largely ineffective and psychiatric services were still "firmly located in the institutions" (Nolan, 1993:10). Compliance was also revealed as

important for patients and was intimately bound up with the granting of privileges as rewards. Aspects of how these systems operated on a local level are revealed by the research in this study.

Although the institutions were hierarchical, confirming extant literature explored in Chapter Two, (Orme and Brock, 1987; Carpenter, 1988) they present in the data in some instances as benevolent autocracies or traditional village-like social structures under the control of a squire-like figure. This figure was the powerful Medical Superintendent who worked in an environment complete with a Church Minister and chapel, Tradesmen, and a farm and Farm Manager. This social structure reflected somewhat the nature of outside rural communities in the latter part of the nineteenth century when many of the institutions were constructed.

Patterns of admission changed somewhat after the introduction of the Mental Treatment Act of 1930 in allowing voluntary patients, and resulting in "the boundary between mental hospital and society becoming more permeable" (Barham, 1992:4). There is evidence in this research study to confirm this view of Barham, in that developments such as units for the new "voluntary patients" had a particular cachet among staff as well as local populations.

These results relating to the nature of earlier hospitals correspond with much extant literature on the asylum system including Scull (1979) and Jones (1972). For example, reflecting on the power of the medical superintendent, Scull (1979:103), comments that they could be a power for good:

"In a properly run asylum, the patients must be seen daily, sometimes hourly, by the man who had charge of the institution. By paying 'minute attention' to all aspects of the day-to-day conduct of the institution, by always setting, through his own example, a high standard for subordinates to emulate in their dealings with the inmates, he could foster the kind of intimate and benevolent familial environment in which acts of violence would naturally become rare."

The focus of this study is on one particular hospital, however, and recording the way the system was expressed on a local level adds to the historical record of that area for the first time. Literature relating to the concept of communities as places of choice and belonging was presented in Chapter Two. Skidmore (1994:104) argues that communities are personally defined. Furthermore he argues that care

> "...by the community does not necessarily mean enlisting informal carers to carry out the role of the professional. In essence, care by the community is the transference of the responsibility of care into the client's world. That may mean using the client's network or self-care by the client."

It could be argued that to sustain this concept requires empowerment of the patient, and could result in almost total withdrawal by the professional.

A contradiction was noted in that such a concept could not be used to define a population, any part of which was held, against its will. Skidmore's concept of community as an internal construct is a theoretical perspective that, while better reflecting present approaches to community care, does not fit easily with longer term involuntary incarceration where there is, or has in the past, been no element of choice. Therefore, were mental hospitals held to be "communities" when viewed from this perspective? Evidence is presented that long-serving members of staff personally defined mental hospitals as viable and supportive communities. This was certainly the case with retired staff from St Crispin Hospital.

A weakness in the research is related to the fact that no ex-patients from St Crispin Hospital were found who were willing and able to recount their experiences. This made it impossible to explore their opinions on this issue. However, some of these patients had certainly not experienced choice in admission as shown in the archive record and had been reluctant to be incarcerated as evidenced by use of Sections of the Mental Health Act (1959). Earlier, others had been "certified". Some, after implementation of the Mental Treatment Act of 1930 and the Mental Health Act of 1959 were admitted as voluntary patients (Archive Material, Northamptonshire Record Office). A number who remained in hospital for many years may have recovered from their original illness. Data was used from other testimony, namely that of ex-patients housed in the National Sound Archive. The element of "patient choice" is revealed, in exploration of these data, to sometimes being limited simply as to whether to participate in activities or not, rather than whether to accede to treatment or detention.

The fact that a concept of community as being personally defined and being formed by participants into a "community of choice and belonging" could not be explored more fully, particularly in relation to one hospital, tends make a rejection of it less secure. A number of patients ultimately made their homes within the institutions (Butler, 1993:20) and spent lifetimes there (albeit often because of institutionalisation and a lack of alternatives). However, the testimony from ex-patients derived from the National Sound Archive, as well as testimony from retired members of staff, tends to reject the concept of a "community of choice and belonging" as being an effective way of understanding mental hospital based services during the pre-war period and beyond. The results indicated that a

theoretical concept of a "Geographical-occupational Community" within which care, treatment and containment was commodified fitted more closely the results of this research.

The study also suggests that the degree of separation between institutions and the community outside, postulated by Gittins (1998) or being "remote" and "isolated" (King, 1991:xiii) and reviewed in Chapter One, was not one of "two worlds" that were starkly delineated from one another as she implies. In refuting this concept, evidence emerged that around the institutions was a network of contacts that included patients, in the post-war period in particular, mixing through work and social activity with the local population. Although there was limited contact, and perhaps stigma, in respect of the larger geographical community, relations with the local community were relatively tolerant and regular. The evidence indicates that this began to change in the case of St Crispin Hospital when, with town expansion, the local village was swallowed up and new residents began to move in. Evidence presented indicates that the concept of mental hospitals being isolated from the world outside is not correct with reference to St Crispin Hospital, and challenges the assumptions made by King (1991) Butler (1993:41) and Gittins (1998). Evidence for this was seen in respect of the local nature of work. The ex-members of staff interviewed in Leicester and Northampton for this project, all lived, during their careers, either in housing near the institution they worked at or, for a time, within its walls. The indications from the oral testimony are that many others did so too. Many later moved into nearby accommodation becoming embedded within the local population.

St Crispin Hospital is revealed as major local employers and an important economic power within the local village and what was originally a mainly farming and stone quarrying working community in Northampton. The historic perception of isolated hospital communities with limited interaction outside is therefore not supported by this research. Skidmore (1997:2) describes a community as "merely a place where people live and work". He further states that "we have lost sight of the fact that hospitals are part of the community." The application of a concept of community in respect of mental health institutions being linked in a much more interactive way with the world outside is, however, a new insight in respect of historical mental health services. A picture is revealed in the data of an "Occupational Community" (Fricke, 1973) not just within the institution but also with a part of the world outside. The business of the institution reveals it as a local industry of care and containment as well as a provider of labour for a geographically based occupational community.

Evidence from this study suggests that the nature of a Geographic-occupational Community was apparently associated with a lessening of stigma towards patients in the area local to St Crispin Hospital. It also reveals how this acceptance began to break down. This breakdown of care in latter-day conceptions of community contrast with a "Care in the Community" approach where the tendency has been to see "community" as "good" and "hospital" as "bad". The fact that discharged patients may have taken up local employment or that others may be receiving care in the community does not necessarily mean social integration. The theoretical concept of a "Geographic-occupational Community" is a new application of this concept in examining the relationships of the old asylums (and later mental hospitals) with the

society around them. It fits easily with the research data and sits more readily with the evidence in this study than the notion of the rigid hospital-community divide.

The occupational aspect of mental hospitals in this period is shown to have applied not only to members of the village populations working within the institutions but also industry, such as farming. Included in the general occupations of the hospital were also sport and music. Work for patients within this environment is revealed by the study as having particular importance. Such work consisted of a mixture of activities including domestic, trade, light industry and farming. It could determine not only special privileges but possibly also the quality of accommodation.

The analysis of the data disclosed a strongly hierarchical environment within the institutions for patients as well as staff. The need to conform existed alongside, for the luckier patients, involvement in the industry of the hospital. These factors reflected the status of most of the earlier patient residents as "pauper lunatics", where the requirements of the workhouse had included labour. The evidence of the crucial role of patient labour in the economy of the hospital supports previous research on the history of Littlemore Hospital in Oxford by Goddard (1996).

The use of hospital farm produce within St Crispin's Hospital's internal economy contributed to the institution's aim to be self-sufficient. No evidence was revealed of surpluses being sold on the open market. The morality of the use of patient labour was increasingly legitimised at this hospital by medical staff in the mid 1950s by designating it as a therapeutic activity.

The recruitment of nursing staff in particular possibly being based partly on sporting ability is recorded in existing literature (Gittins, 1998:173). Evidence in Chapter Four indicates support for the view that sporting (and indeed musical) abilities might have been influential in some instances in recruitment. There is also archive and film material, as well as personal testimony, that sport and related social activities played a large part in the off-duty activities of staff. Cricket and football matches that may have included patients are also recorded. These results are supportive of evidence in previous research presented by Goddard (1996) and Nolan (1996:96). Goddard (1996:35), for example, in describing musical, sporting and other leisure activities in Littlemore Hospital states:

> "Music and sport continued to be highly valued in mental hospitals and in the 1950s nursing recruits were required to mention any talents they might possess in this direction on their application forms."

As described in Chapter Four, there was a strong gender divide in the hospitals and male and female patients were governed by strict rules. This supports published literature by Gittins et al (1998). Many differences existed between these two halves of the service. This may also have been reflective of different attitudes between nurses and patients determined by gender. For example, there is evidence of supportive activity, in particular by female nursing staff in a Leicester hospital towards patients who had lost contact with their relatives. They conceived of themselves becoming as family to the patients in their care.

Oral evidence from a Northampton nurse in the pilot study, that potential recruits for nursing were targeted from outside communities and not the town local to the hospital village, in the pre-war period, was not supported by any other evidence in

the study. If such a policy was pursued initially, it was most likely to have been discontinued in the post-war period due to acute recruitment difficulties.

In Chapter One, documents are revealed in archive material and supported by oral testimony of a wartime and immediate post-war crisis within St Crispin Hospital. That crisis influenced attempts to initiate change and reform. This occurred at a time when the newly founded National Health Service was combating some of the previous underfunding. In Chapter Five, oral testimony and documentary archive material revealed strategies that were developed at the time by key, charismatic and influential, individuals. This work revealed the importance of "key" individuals at this time in initiating change. The roles of people and not just policy initiatives are revealed as important. This is supportive of existing literature (Plekhanov, 1940) and will be further explored next.

Part Two: Voices on mental health communities 1950 – 1965: The Demise of the "Geographic-occupational Community" and origins of the "Community of Interest".

The evidence from previous studies (Butler, 1993:3; Barham, 1992:6) suggests that the legacy of the old asylums proved very resilient. One factor revealed in this study was the characterisation of hierarchy and authority surviving in the form of nursing uniforms. Until the post-war period, this included, for men, uniforms very similar to those worn by prison officers. The presence of a uniformed nurse was seen by a female contributor as being re-assuring to patients and relatives. Conversely, a male contributor felt that they put a distance between male nurses and their patients, portraying them as figures of strict authority. A feeling of discipline is shown to

have permeated the male wards in particular at St Crispin Hospital. The effects of uniforms for staff on the nature of a community are reflected in the research data. On the other hand, the research indicates that in the period of a freer social outlook in the post-war decades of the 1950s and 1960s, these postures were becoming untenable, re-inforcing the conclusions of previous studies including that of Butler (1993:39) who comments on the "running down" of the hospitals as being related to two meanings. First, the increased expectations for change at the beginning of the 1960s created by the 1959 Mental Health Act, and second, "the sense of unease which persisted and increased regarding the purpose of the mental hospitals and the quality of life they afforded for their resident patients." Scull (1979) considered the main motivating force in hospital closure to be economic. Tomlinson (1992:49) argues that there were five stimuli for mental hospital closure. The five were:

(a) Government guidelines.

(b) Professional value choices.

(c) The performance and accountability review system by which Health Authorities' progress against targets is measured.

(d) Mental health administration issues.

(e) Pressure from concerned groups such as Community Mental Health Councils and MIND.

The evidence of the data supports this previous research but adds to it the role of individuals including one group whose activities early on have not been adequately recognised in existing studies, namely in-hospital groups of volunteers. Hospitals were designated for closure but in the period prior to this, the immediate post-war crisis was present and needed to be confronted. In addition, some of the moves to

deal with the crisis would have an effect on the development of new services. These factors will be explored next.

A particular catalyst for reform and change in St Crispin Hospital is revealed in an exploration of data related to the war and post-war crisis. This was demonstrated as urgency for new ideas to solve major problems related to overcrowding and the poor conditions under which many patients were being forced to live, staff shortages and structural decay. The results of the research are important in understanding how staff within one hospital set out on the path to improvement after what had been a very difficult time. It takes a micro perspective of issues that is often missed in a formal history of policy changes. The roles of individuals in a social process are demonstrated as important in the research findings, including in this respect the role of powerful and/or charismatic and innovative men and women. For example, earlier in this chapter, the power of the medical superintendent was considered. Scull (1979:103) postulates this power as a potential force for good. In the immediate post-war period, and faced with a crisis at St Crispin Hospital, a reforming Medical Superintendent spoke at meetings of such organisations as the Standing Conference of Women's Organisations and invited visits to the hospital by its members. This provided an initial outside "gaze" from early volunteers and led to the founding of the first League of Friends in a mental hospital in England and Wales. A powerful force in initiatives such as this and the role they took was a dynamic and influential woman, identified as "Mrs X" in the results Chapter Five, who became chairman of the Hospital Management Committee. A new, reforming Chief Male Nurse oversaw male nurses abandoning uniforms and nurses supervising the construction of garden features in areas where the now demolished walls had previously been. A nursing

initiative at St Crispin Hospital established an industrial therapy unit. This was later supplemented by an industrial rehabilitation workshop, also run by nurses, with an ultimate objective of the re-employment of patients in industry.

Occupational therapists developed such rehabilitative initiatives as cooking classes as did volunteers early in their involvement. Without these initiatives, and others, the hospital could have become increasingly isolated, as the "old village" was absorbed more into the town proper and the old "Geographic-occupational Community" broke down. The results may also aid future research in providing one reason why some institutions changed at a different rate to others and in different ways.

Butler, (1993:3) refers to changes in mental health policy being reflective of "complex and powerful shifts and changes both in society and in the policies established by successive generations." The findings of this study do not refute Butler (1993) but indicate that although policy shifts and social changes were underlying forces, the roles of particular individuals were also important. Plekhanov, (1940:23) critically appraised the more extreme critics of "subjectivism" in exploring the role of the individual in history. In acknowledging the role of individual influence he comments that "...they were evidently prepared to forget that men (sic) make history, and, therefore, the activities of individuals cannot help being important in history." In the social climate after the Second World War with recent experience of the horrors of the effects of totalitarianism, the evidence reveals a drive for change nationally, with the beginning of the welfare state in 1948. The dynamism of particular individuals, revealed as taking a leading role in this process,

at St Crispin Hospital, is shown as important, not simply the following of central government initiatives.

Structural decay and the poor morale that accompanied it, are noted as important in the post-war crisis at St Crispin's Hospital. It is revealed that backing from nursing and other staff in the initiation of change supported senior nursing and medical staff, enabling reform and the provision of leadership. These findings modify the notion of progress being simply a mechanical process brought about by social change, policy change and legislation. They emphasise the importance of the individuals who make change take place.

The gradual decay of locally based occupational communities revealed in the data, uncovers some additional factors as follows. Changes occurred with organisational and service changes that were nationally implemented. These include the expansion of the day hospital services and the community psychiatric nursing service. Others that have not been revealed before this study include the social changes in the locality of St Crispin's Hospital that reflected the end of the old and more tolerant village population as town expansion, new sources of employment and labour mobility developed. The "old village" was replaced by the "new village" where previous levels of acceptance did not necessarily exist and the beginnings of modern day community concern about the putative hazards posed by 'mental patients' could be detected.

Included in reforming initiatives taken at St Crispin Hospital, as noted, was one to invite "outsiders" into the hospital as volunteers in the early 1950s. This is suggested

as one of the origins of "Communities of Interest". Opening up the institutions to the scrutiny of others who did not originate from associated professions or officially appointed visitors is demonstrated as important. The alternative gaze that these volunteers provided, contributed to enlightened changes that were being sought. MIND and other organisations developed to operate outside hospital settings also, within the same period. The results from this project are new in identifying this earliest post-war input. The research revealed the earliest origins of "Communities of Interest" and focussed on those who initially provided an element of public service and/or support to relatives and friends.

The notion of "Communities of Interest" was introduced in Chapter Five and found to be a useful theoretical concept for understanding the increasing involvement of volunteers in working with mental health patients. The study found that the role of early volunteers in the historical record dedicated to hospital-based work is neglected. Gittins (1998) does not mention volunteers at all in the narratives of Severalls Hospital. Jones (1972) comments on the voluntary mental health services and the Feversham Report of 1939. This report made recommendations for future development. The four voluntary associations operating on a national scale in the mental health field were identified. These were The Mental After-Care Association, The Central Association for Mental Welfare (founded as the national Association for the Care of the Feeble-Minded in 1896), the National Council for Mental Hygiene and the Child Guidance Council. Amalgamation of these of these four main central agencies was recommended.

Jones (1972) notes a "shift" in the role of voluntary organisations after the founding of the National Health Service in 1948. There is however, no mention of the development of new localised initiatives in mental hospitals. No mention is made of volunteers by Foss and Trick (1989) in a history of St Andrew's Hospital. Brief mention is made by Barham (1992:134) of the regional director for a national mental health charity arguing "that we are witnessing a gradual "voluntarization" of the welfare state, a process in which voluntary organizations are being used as an insidious tool by the government in the privatization of the public services", though this surely refers to a later period when voluntary groups were more established, and neglects their earlier, and arguably more positive role. McCourt Perring (1993:36), talks of the role of voluntary agencies in setting up community based services and the effect of the NHS and Community Care Act 1990 on them within "a mixed economy of care". However, McCourt-Perring makes no mention of the origins of the development of particular voluntary services within the institutions and any particular needs to which they were responding.

At St Crispin Hospital, the initiatives developed by volunteers are revealed to have developed early, comprising pioneering interventions in overcoming problems arising from a previous period of hardship. As already noted, volunteers were invited into St Crispin Hospital as part of an initiative to defeat stagnation. Innovations are revealed such as a patient's hospital shop and later a boutique at a time when the clothes of many individual patients were still centrally issued and stamped with the hospital name.

Grounds are presented of the benefits introduced to St Crispin by the opening-up of the hospital to not only voluntary service organisations but also individuals such as artists. An apparent "sea change" in attitudes and interest towards St Crispin Hospital by "outsiders" during the 1950s is revealed. This is compared to attention previously displayed by middle and upper class individuals towards a local private and charity based hospital. Interest from the BBC in a special Mental Health Project at St Crispin in 1963 is described. The importance of voluntary services is acknowledged locally as an important development towards community care. These results are important and under-recorded for they track, on a local level, the genesis of the development of communities of interest, the expansion of a recognition of the individuality of patients and the opportunities, and forms of governance, made possible by the conception of an individuality defined by the ability to make choices.

The significance of this is shown to be the role of voluntary organisations in providing for the first time a true "outside gaze" within the long stay wards of the institution. This material is important in that it reflects one of the origins of voluntary organisations that now play so important a role, including in service provision. In view of this fact, the neglect of the history of this pioneering in-hospital and other groups, the services they provided and the roles of individuals driving them has been a serious omission from the historical record. Such under-reported activities include training in cooking skills first initiated by volunteers at St Crispin Hospital in Northampton. Allied to voluntary involvement were initiatives from members of staff, including nurses and doctors, and the beginnings of more professional health work based in the outside community. Included in these developments were outpatient clinics, and early examples of day hospitals. The

concept of communities of interest provides a theoretical explanation, which fits well with this research, of post institution mental health services arising from the gradual breakdown of previous geographic-occupational communities.

The results of the research indicate the importance, in the development of psychiatric services, of the contribution from an initially multi-regional and later a multi-ethnic, multi-cultural workforce. Evidence of the introduction of new attitudes and ideas into the service by this means is presented. For example, one female nurse "E", who arrived from the West Indies, felt that she brought with her a cultural outlook that was important in her work with elderly patients in mental health in Britain. "E" explained that people were used to caring for the elderly in the West Indies and that when she lived there, although she did not have any immediate family living nearby she supported an elderly person next door to her. She did this by shopping, making calls and getting food ready and felt that this was like a family link. The nurse explained that she felt this cultural outlook gave her versatility as a nurse.

The research results show that different approaches were being employed in terms of therapeutic activities in the immediate post-war years. At the same time, a general policy of door unlocking was being instituted at St Crispin Hospital and elsewhere. As revealed in previous research, new drug therapies were also being introduced (Welshman, 1999:209; Jones, 1972:294). Physical treatments such as Electroconvulsive Therapy (ECT) were still in use but others such as Insulin Therapy fell out of favour. As we have seen, there are conflicting opinions as to the relative importance of new Phenothiazine medications such as Chlorpromazine

(Largactil) in initiating change. The exploration of this subject in the research revealed that staff who witnessed its introduction believed it to have had a significant impact. Patient testimony was of a drug that inhibited function and had unpleasant side-effects. These are contradictory positions but can be reconciled in support of previous literature and oral testimony. For example, Gittins (1998) acknowledges that although not providing the hoped for cure (and restricting from a patient point of view), new treatments may have engendered a more relaxed regime on wards. Staff may also have been encouraged to take more risks in instituting changes. In addition, new treatments increased staff attention towards patients who were receiving them. The results demonstrate that it is still not clear whether the drugs made possible the "open door policy" and other changes or if they would have developed anyway. The data indicates that a change in attitude and approach to care, as well as new treatments, were contemporaneous and complementary.

Part Three: The "Community of Risk".

The research also explores changing nature of risk in mental health services. This study suggests that the nature of risk has changed. This is not to say that an awareness of risk in mental health services has not, historically, always had prominence. The concept of risk is revealed as having existed in the discourse of the "Geographic-occupational Community" but largely within its confines, policies and protocols. The associated local population tended to be tolerant of low level deviant behaviour. This correlates with published literature and archive material. Chapter Six identified the origins of the theoretical concept of the "Community of Risk" in mental health that has developed reflecting wider social change. Although as a theoretical tool this concept is held to come into its own in the latter part of the

twentieth century, its genesis can be traced in the "Geographical-occupational Community".

In the case of St Crispin Hospital, difficulties were recorded in the data of a time when a new population had started to settle in the area of the hospital (new village) as the old "Geographic-occupational Community" was breaking down. With the closure of the institutions, the nature of the fear of risk has changed in that it is now a much more central concept that has moved into the general population. The early "new village" manifestation of negative attitudes recorded at St Crispin Hospital could be argued to now be a much more general perception.

The evidence reveals that after the development of policies of community care, the element of risk becomes more centre-stage. The management of risk is revealed as still being discussed within the "Community of Interest" of staff, voluntary sector and patients, but with the mechanisms of governance also being moved outside the institution. The general population increasingly becomes part of the risk equation. Strategies designed to control risk are explored including legislative change, local and national policy development and organisational initiatives such as crisis intervention teams and risk assessment strategies (Donald, Lancaster and Forster, 2001:16). Next, Table Five demonstrates the different guises of risk in mental health over the three periods outlined by the author, and how this relates to what the author perceives as different modes of governance associated with the three types of mental health communities.

Table Five: The historical nature of perceived risk and response in mental health

GEOGRAPHIC/ OCCUPATIONAL COMMUNITY ——>	COMMUNITY OF INTEREST ——>	COMMUNITY OF RISK
Where		
Geographically local. Within hospitals and (largely pre-admission) among the general population.	Within hospitals, other in-patient services and increasingly among the general population.	Within in-patients units and among the general population.
Mode of Governance		
Hospital based often custodial, and containment but with early out-patient clinics after 1930 (St Crispin Hospital).	Assessment, observation, detention where necessary.	Assessment, observation detention where necessary.
Limited effective treatment.	Treatment/social care.	Treatment/social care.
Institutional procedures, including for escort and observation.	Evolving assessment strategies, legislative change. (inc. 1983 Act)	Assessment strategies including: Risk assessment - care and management, plans and protocols. More inter-agency working.
	Organisational innovation. (E.g. crisis teams, multi-disciplinary teams)	Information Technology. (E.g. Use of ePEX-3)
		Increased scrutiny. Possible new legislation for potential offenders. Tighter regulation.

Risk assessment strategies have been considered as central in characterising contemporary mental health services. The mechanisms utilised in such risk assessments are especially noteworthy. These mechanisms are based on bureaucratised systems often using computer record keeping. The consequences for patients, the general population, volunteers and staff of failure or perceived failure

are considered. The importance attached to training is identified. Proposed legislative change and the events that originated it are explored.

Conclusion.

This chapter has briefly explored the results presented in chapters four, five and six and their key outcomes. The results have been considered in respect of the literature reviews of chapters one and two. The data gathered in this research has been utilised in an historical account of a time and place, St Crispin Hospital between approximately 1935 and 1965. The research exploration has been divided into two periods, 1935 to 1950 and 1950 to 1965. This division does not reflect a sharp, mechanical view of progress. It is, however, reflective of a watershed crisis occurring during wartime being followed by a rise in innovation and reforming initiatives beginning in the immediate post-war period.

Previous research that has arguably been partially refuted by the research findings included the following. The results did not reflect a strong dividing line between the institution and the community local to the hospital during, in particular, the immediate post-war period. This refutes Gittins (1998) and Butler (1993) who emphasise a division that implies two separate worlds. The role of St Crispin Hospital as a major employer contributing to the local economy is revealed in exploring the way in which the hospital was embedded in the local area. Oral evidence of a preference in nursing recruitment for individuals from non-local areas could not be supported generally by the research.

The study also critically explores the notion of community being "good" and hospital being "bad". The hospital patient population is revealed to have lived in what appears to have been, for a considerable time, a relatively tolerant local environment where some were familiar figures who may have had jobs near the institution. However, a concept of community revealed in the literature as "personally defined" (Skidmore, 1994) or resulting from "a sense of belonging", (Plant, 1974) is refuted in this project as fitting poorly with the data. This related in particular to the involuntary nature of entry into mental health services for many of the patients.

Key elements of existing literature were confirmed. These confirmations include the hierarchical and controlling element of institutional life that was evident in the hospital system before, during and beyond the 1930s. Also confirmed were the details of institutional life outlined in previous literature that had clear parallels at St Crispin Hospital, which was the focus of this study. This includes the role of patient labour in the institution and is supportive of previous work by Goddard (1996). Previous research on the influence of sporting ability in the recruitment of nursing staff has tended to be supported, as has the nature of the strict gender divide in hospitals, particularly during the period 1935 to 1950.

The importance, to initiatives of reform, of charismatic and sometimes powerful individuals revealed in the data has been recorded. A general neglect in the hospital-dedicated literature of initiatives developed in the institutions, during the early post-war period by voluntary agencies has been identified. In the case of a League of Friends founded at St Crispin Hospital, it is revealed that this was the first such

organisation in a mental hospital in England and Wales. The study explores and records for the first time, the role of voluntary services in the post-war period in helping staff to overcome a crisis in the institution. The research also confirms a belief among local people and staff of units originally built pre-war for new voluntary patients as being "special", and the perpetuation of that belief among some in the local population.

In analysing the data and presenting this account, an idea of changing discourses of community has emerged. The identification of three theoretical models of community that describe important aspects of mental health services between 1935 and 1965 is presented. These three concepts of community are arguably key theoretical tools that could be used in other studies of the history of mental health. The three conceptual models developed are as follows:

(1) The Geographic-occupational Community.

The nature of a Geographic-occupational Community has been revealed and also its gradual decay and breakdown due to social, economic and policy change.

(2) The Community of Interest.

The development of a Community of Interest is identified with the increasing role provided by volunteers in working with mental health patients. Along with national developments such as the founding of MIND in the 1940s, the research identified the beginnings of voluntary work in St Crispin Hospital. The theoretical concept was developed as a tool to identify these changes and fits well with the research data.

(3) The Community of Risk.

This theoretical concept derives from having explored the changing nature of the concept of "risk" from its origins, largely within the geographically enclosed area of

the mental hospital. The nature of "risk management" within the general population has been explored from the perspective of national and local organisational, policy and legal change.

A re-assessment of the importance of new treatments such as Chlorpromazine, and other drugs in the phenothiazine group, in the initiation of change in the post-war period has been outlined. Evidence revealed in previous work, for example by Gittins (1998), is supported, in that such treatments may have provided a more relaxed environment within which staff were more involved with patients and prepared to take some risks.

Weaknesses in the research process have been identified and in particular a failure to recruit local ex-patients who were willing to be interviewed. The implications of this are that particular voices have been silenced. It is ironic to say the least that the bureaucracy of contemporary research governance frameworks, themselves reflective of risk management strategies, have contributed to this silencing of service users.

In this chapter, the author has tried to summarise the different concepts of community encompassing mental health in terms of both location and modes of governance. In terms of location, the "Geographic-occupational Community" was self-evidently based around a small local geographic community. The smaller geographic locale of the hospital was interlinked with the local community in terms of staff recruitment and local work economies.

With the community of interest, the focus of the location is still the hospital, but the space is increasingly medicalised. Other spaces now include outpatient services and medically approved periods of leave or therapeutic work beyond the hospital. With the community of risk, the location is in smaller in-patient units and within the general population.

The mode of mental health governance also changes. The early hospital location is mostly custodial, with an emphasis on physical containment, although St Crispin had an early outpatient clinic soon after 1930. Treatment was limited and largely ineffective, confirming the Foucauldian proposition that the medical men acquired their knowledge through the exercise of power and not vice-versa. There was also an emphasis on institutional procedures for locking doors, for observation and for escorting patients. With the "Community of Interest", physical detention becomes seen as a governance of last resort, with assessment, medication and observation as primary modes of control. The work becomes treatment and social intercourse and contacts become social care.

The "Community of Interest" implies that everyone has a responsibility and a stake in the mode of governance, and the multidisciplinary team can be seen as an effect of this mode. When the "Community of Risk" really takes hold in the latter part of the twentieth century, the assumption is that treatment within the general population should be the norm. In order to achieve this, assessment becomes focussed on assessing risk as the prime mode of governance in assessing need. The mode of governance is extensive and incorporates not only risk assessment, but planning, protocols that counter professional innovation, and inter-agency working to ensure

no one slips between the different arms of risk control. Serious mental illness becomes re-positioned as representing a continuous potential risk, and anticipatory interventions are now believed necessary to be invoked, by government.

The conclusion, Chapter Eight will next assess the results in terms of their importance and identify original contributions.

CHAPTER EIGHT

CONCLUSION

(1) The original contribution to knowledge.

Introduction.

This research project has been developed out of an earlier research project, in order to further explore the historical nature of communities around mental hospitals. The research has drawn on data from a number of sources, but has focused on services at a particular time and place, namely St Crispin Hospital in Northampton. A pilot study provided the opportunity to develop an appropriate research methodology with which to explore the nature of theoretical concepts of community in mental health between 1935 and 1965. A research tool was developed, using a modified grounded theory approach combining the oral histories of ex-staff and patients with other, documentary, sources. A literature search and the pilot study identified weaknesses, such as an assumption of an overly sharp divide in the respective concepts of hospital and community. Many of the results obtained accorded with previous research. However, the research study has also revealed specific contributions to knowledge and perspectives on concepts of community in mental health. Each chapter will next be re-visited and the contributions to knowledge identified.

FINDINGS OF THE RESEARCH

Chapter One: The research project began with a brief exploration of the history of the mental health services from 1860 to 1965. A review of the literature exposed inconsistencies between this literature and the author's previous study that was the catalyst for this thesis, especially the notion of a rigid separation of hospitals and the

communities local to them. The review also provided other areas worthy of further exploration, including the role of the voluntary sector post-war, the contribution of new drugs, and the place of charismatic individuals in effecting change.

Chapter Two: Concepts of community that could apply to mental health were reviewed in this chapter. The concept of communities being defined by their members' ability to choose to join and based necessarily on feelings of belonging was noted as a characteristic of some existing literature. The wider literature on community drew the author's attention to the manner in which hospitals could comprise communities, and that at one and the same time, hospitals could be relatively co-terminous as a community with the old village in which the physical building of the hospital was situated.

Chapter Three: This chapter discussed the development of an appropriate research methodology to explore conceptualisations of community in mental health, focussing on a particular place and in a particular time, namely at St Crispin Hospital in Northampton between 1935 and 1965. The methodology was critically appraised with strengths and weaknesses revealed. Tactical developments adopted in the light of experience have been discussed. The main points revealed in the development of the research process are as follows.

- The development of the research methodology utilised interviews with nursing, medical and ancillary staff as well volunteers and other witnesses to the operation of mental hospitals. Archived documents, film and photographs were also used as sources of data. The nature of such data as representing the

priorities of the most powerful groups, produced either for official records or for general public consumption was noted. The importance of introducing the perspective of the weakest, the patient was made difficult in that local individuals did not, after much effort on the part of the author, and others, present themselves for interview. The lack of a local patient "voice" created an acknowledged weakness in the research that led to a decision to utilise "proxy" material derived from interviews with similar patient groups held at the National Sound Archive. Some limited and initial checking of analytical concepts, from this perspective, was developed by such means. A method of dividing the data into two contrasting periods and thereby emphasising important developments in the conceptualisation of what is meant by community in mental health was developed.

- The research process has successfully enabled the development of an analytical tool combining a modified grounded theory approach with oral history and other sources. This has provided flexibility as well as the ability to develop in-depth understanding of the views of interviewees and provides potential guidelines for further research projects.

Chapter Four: This chapter explored what factors, at St Crispin Hospital shaped concepts of community during the period between 1935 to 1950. The intention of separating the patient population, from the mainstream, by the building of what were initially known as asylums was noted. These buildings such as St Crispin Hospital, the focus of the study, were often built in rural communities on the edge of towns.

Findings revealed by the research process are as follows:

- This project has revealed that interpenetration of the asylum and local village community was made possible by factors that include the following; the local recruitment of staff; traditional ties; parallel hierarchies based on local tradition and status: overlapping work economies of mutual benefit (for example, some free patient labour and a reduction in taxation for locals by a self-sufficient asylum) and some activity in the local community by trusted in-patients.

- The theoretical concept of the "Geographic-occupational Community", developed in this research, represents a concept of community where the hospital provides employment for a workforce largely living, and sometimes partly recruited, from the immediate locality. Different generations of the same families may have worked within the local institution. Patients, as noted above, provided labour for the economy of the hospital. The hospital had echoes of a hierarchical village community and the "old village" was relatively accepting of the patients.

- This study has refuted the notion that there were necessarily clear dividing lines between a mental hospital and the outside community "at the gate". St Crispin's Hospital has been shown to have had a mechanical solidarity with the local village with geographical and social interpenetration. The hospital provided a local industry of care and containment and this represents a new way of understanding such communities. The staff-side industry of the mental hospital had developed around issues of categorisation, supervision, support and containment. The influence of mental hospitals within local areas of occupation

has also been shown to have been considerable, and under-explored in extant literature. This is a new perspective in understanding the nature of the communities of which mental hospitals were a part. This concept represents a new way of understanding the nature of mental hospitals and the communities associated with them. Moreover, it provides a potentially valuable analytical tool for further research.

- The extent to which additional new buildings for "voluntary patients" became separated, in the psyches of staff and some in local communities, from the stigmas of the old asylum buildings has been explored and found to be significant. This is an interesting new addition to local history not known to have been previously recorded.

- The concept of communities formed of members by "choice" who have "feelings of belonging" was rejected as being inapplicable to mental health to the extent that coercion was, and is, a recognised means of admission. This insight requires at least a modification of the assumption that the nature of "community" in relation to mental health can be adequately analysed in terms of a sense of belonging. The research process suggests that the concept of the "Geographic-occupational Community", where work and geography imply elements of both constraint and choice, mapped more closely to the data. For instance, the research did reveal that, often, despite not having had a choice about admission, some might have developed a feeling of "belonging". Thus being in hospital may not always have been equated by patients with "bad" and outside as "good".

Furthermore, being outside may not necessarily be equated with being "integrated" and inside as being "segregated".

- The research process revealed detail of the internal patient labour economy operating in St Crispin Hospital. This is new local history not having been previously documented. As well as saving on expense to the local rate payers by developing as much self-sufficiency as possible through working farms, other workshop industries such as tailoring, dressmaking, engineering and gardening were also established and involved patient labour. Much of this work may have had therapeutic effects but attention has been drawn in the project to activities that had other, real, economic results in developing a self-sufficient capacity for the hospital, particularly with regard to farm and garden produce. The research has indicated that this activity needs to be viewed in more than one way, not simply as therapy but also as labour serving the economy of the hospital and thereby reducing costs, suggesting the continued spirit of poor law relief.

Chapter Five: This chapter explored what factors, at St Crispin Hospital shaped concepts of community during the period between 1950 to 1965. Findings revealed by the research process are as follows:

- The examination of a wartime and post-war crisis in St Crispin Hospital and how reform was initiated demonstrated the important role of the leadership of charismatic and/or powerful individuals, nurses, doctors and others. This represents a substantive addition to the local history of a particular situation in one hospital, St Crispin. It is a useful new addition to knowledge in

understanding how a particular hospital avoided the decline that affected others. In other places, in the most dramatic instances, this led to public enquiries. The research demonstrates the importance of individuals to progress rather than simply, for example, policy change. However, an impulse for change was partly driven by policy, from the early 1960s, with a decision to ultimately close the mental hospital system.

- New evidence has been revealed of the sometimes-important role of hospital-based volunteers in the initiation of change following post-war crisis in St Crispin Hospital. Neglect of these services in the literature, with a concentration on those based in the community, has been identified. New knowledge has been recorded about the role of The St Crispin Hospital League of Friends and influential individuals associated with it. The League is shown to have been the first in a mental hospital in England and Wales and provided an early outside "gaze" into the institution. At the same time that these developments were taking place, ties based on deference to hierarchy and tradition were beginning to break down.

- The theoretical concept of the "Community of Interest" was developed as an analytical tool to understand the way in which mental health patients became linked and even integrated within an "outside" community that included volunteers, as the "Geographic-occupational Community" gradually broke down. This has provided a new understanding of the origins of the development of services, which have evolved subsequently.

- A post-war desire for reform, a social revulsion of poor conditions for patients and staff, exacerbated by labour shortages, combined with a relative lack of tolerance of institutionalised patients by "new village" life combined to make patients, staff and volunteers part of a "Community of Interest" where certain developments are of seemingly mutual interest.

- A re-assessment of the importance of new medical treatments in the post war period (and in particular Chlorpromazine) was supportive of existing literature. The new drugs may have had not just a pharmacological effect but also heightened staff attention and inspired a greater willingness to take risks with those receiving the treatment. The results therefore indicate a complementary effect between regime reform and new treatments. This exploration is important in that it adds to the body of work already carried out on what has sometimes been a contentious issue.

- The research has further revealed how changes began over the period between 1950 and 1965 because of factors that included increased geographical and social mobility. Hospital workers, as with factory workers and others, no longer needed to live within easy distance of their place of employment. Increased car use meant that patients and staff needed no longer to live ideally in one geographical location.

- The recent experience of the Second World War with revelations of the depersonalising effects of forcible incarceration brought an urge for reform. This was enhanced by a wave of optimism with the founding of the National Health

Service in 1948. This development increased the power of the medical profession in controlling the mental health service.

Chapter Six: This chapter explored a concept of the "Community of Risk". Findings revealed by the research process are as follows:

- The theoretical concept of the "Community of Risk" has been developed in this research project as a tool to explore the growing nature of the emphasis on risk management in mental health services The nature of risk in mental health today is revealed as being perceived to be more widespread and to have become the primary mode of governance.

- The "new village" phenomenon identified in relation to St Crispin's Hospital, and conceivably in respect of the growth of new suburbs in other towns, has led to a changing outside community increasingly less attuned to provide tolerance and care. The interests of patients and staff diverged, and changed, as staff began to manage "risk" that was no longer so locally contained, but that was managed on behalf of a wider community. The research reveals that risk has always been present in mental health, albeit that in the past, after admission, it was usually managed within the confines, procedures and routines of a localised mental hospital.

- It is shown that increasingly, the focus of care in the community has seen the triumph of that mode of governance that has been defined as the "Community of Risk." In the geographic-occupational mode of community in mental health,

there were always strict policies controlling potential risk, such as cards authorising various levels of parole. Informal checks and the controlling influence of a close and disciplined environment accompanied these, however. As such a community now does not exist outside small specialist in-patient units, a panoply of tools is now brought to bear. These include policies of risk assessment, formal plans, protocols, connections between agencies, and with threatened legislation for compulsory detention as a spectre held up to haunt those who do not identify with required forms of behaviour. Such changes are themselves driven and made possible with the potential provided by the revolution of information technology. A lot less could be achieved in this proliferation without telephones and computers. This concept of the "Community of Risk" represents too a new analytical tool with the potential for use in further research.

A brief outline of some of the cultural, economic, social, philosophical, technological and policy changes that have influenced and altered attitudes to, and provision for, those deemed mentally ill, and thereby contributed to changing conceptualisations of community in mental health will be presented next.

The following factors have been revealed as among the most important by this research:

Cultural

- Traditional authority became insufficient justification for confining thousands of individuals in massive institutions for mental illness.

- New and optimistic social attitudes following the Second World War and the establishing of the National Health Service in 1948.

Economic

- Structural decay of the old institutions requiring a large financial investment.
- Extra funding with the founding of the National Health Service in 1948.
- An increased level of labour mobility both nationally and internationally.
- Poor levels of pay for staff such as nurses.

Social

- The establishment of the National Health Service further strengthened a medical model approach to mental illness.
- Social mobility.
- Post-war labour shortages

Philosophical

- Interest in, and action, in respect of human rights.

Technological

- Development of better means of personal transport and its widespread use, as car (and other forms of transport) ownership multiplied.
- The development of new drugs, specifically for mental illness.
- Improved communication technology (e.g. telephone) and its mass usage.
- The development of information technology with computer use and electronic networking making feasible a proliferation of programme material such as the

Care Programme Approach and Case Management, that incorporate risk assessment.

- The development of mass media.

Policy

- Enoch Powell and the proposed closure of the institutions.
- The development of policies and protocols governing risk management.
- Mental health legislation such as the Mental Treatment Act (1930), The Mental Health Acts of 1959 and 1983 and a proposed new Mental Health Act.

Chapter Seven: This chapter revisited what has been discovered in the results of the research, with regard to questions arising from the literature search and pilot study. It provides (Table Five) a synthesis of the novel ideas contained within the thesis, outlining historic change at St Crispin Hospital reflecting developments in both the geographic nature of mental health communities, and the changing modes of governance that characterise them.

(2) Areas for further study.

The nature of this research project into theoretical concepts of community in mental health has been wide in scope. Research involving a closer focus on some aspects would be important. Among areas of interest that are of value for further study are the following:

(1) The use of the three theoretical concepts of community, developed in this project, the "Geographic-occupational Community", the "Community of

Interest" and the "Community of Risk", as analytical tools in exploring other services. For example, the rejection of a clear line between hospital and community, particularly in the immediate post-war period in relation to St Crispin Hospital, developed with the theoretical concept of the Geographic-occupational Community. This concept would be of value in conducting further research, and could be tested by examining the history of other institutions and services.

(2) Further exploration of work carried out in mental hospitals by voluntary organisations needs to be carried out and added to the extant dedicated literature of hospital services in this period.

(3) It is important that the contributions made by significant individuals be recognised. This project has not been able to record the working biographies of specific nurses, doctors, occupational therapists, volunteers and others who made important contributions to progress in mental health services. This applies in particular to work carried out in the immediate post-war period in St Crispin Hospital and may apply equally to other institutions. This work would need to avoid the trap of becoming a history of elites in the field of mental health, but nevertheless still recognise the human agency of individuals in the process of development.

(4) Further work on the exploration of patient labour working patterns in a wider range of hospitals would be of value in developing a fuller understanding of the economics of the old institutions.

(5) Most significantly, the research attempted, and failed, to give a voice to the central characters in the story of mental health and community. It has been surmised that these voices have been silenced by a variety of factors. These factors include selective historical attrition that means that those of lower status, such as ex-mental hospital patients, are more likely to die earlier than those of higher status; the possible continued stigma of mental health; the undermining of the sense of survival that revising institutionalised experiences would represent; and the very risk communities represented by research governance frameworks that leave the activities of the powerful unscrutinised and the experiences of the less powerful patients silenced. Finding a means to give a voice to the patients of earlier eras of mental health communities will be the most challenging of all these potential future avenues of research.

APPENDIX ONE: Basic text copies of documents presented to, and approved, by Northamptonshire Local Research/Ethics Committee.

De Montfort University

Faculty of Health and Community Studies

Advance approval of activities involving human research ethics

Title of Activity: "Concepts of Community in Mental Health, 1935 to 1965".

Researcher/Student Name: Rodney J. Griffin - PhD Student

Supervisor Names: 1: Dr Simon Dyson
2: Prof. Hazel Kemshall

Brief Description of activity objectives:

Research that includes Oral History method along with other sources:

1. To explore the history of the concept of "community" in the context of mental health provision from 1935 to 1965.

2. To develop a multi-strategy methodology that uses different sources, including those, which originate from groups associated with and local to individual mental hospitals, "giving a voice" to those involved.

3. To use the research approach to develop an original understanding of the theoretical origins of the development of modern concepts of "care in the community".

As the group being targeted for oral history interviews are human subjects with either previous or current mental health problems (resulting in hospital treatment around the period from the mid nineteen thirties to the mid nineteen sixties) permission is being sought through the DMU and LREC ethics committees. The following procedures will be developed to meet the ethical requirements of this research:

1/ Informed Consent – Each potential subject will be met, subject to their agreement, in an environment chosen and at a time suitable to them. If they wish, a friend, relative, care worker or appropriate other will be present during an initial meeting and subsequently.

A participant information sheet (see attached) will be presented, explained, and a copy left with them to study and consider before any decision is sought for consent to an interview. Any anxieties will be explored and explanations offered.

2/ Anonymity. No individuals will be named in transcriptions and/or written reports.

Risks: A limitation that may exist is potential identification by the association of individuals with particular incidents when evidence is presented. This will be explained, as will the fact that efforts will be made to exclude such dangers when material is analysed.

3/ Confidentiality. Tapes will be marked only by a code letter and the names of the individuals will be kept in a separate notebook. Tapes, transcripts and the coded identification notebook will be kept separately, in a secure, locked environment. Control of the information derived from the interviews will conform to the current Data Protection Act.

4/ Copies of the guidelines of the legal requirements and guidelines outlined in the Code of Ethics of the Oral History Society and the Statement of Ethical Practice within The British Sociological Association Guidelines will be given to the subjects. Information on copyright and any other relevant issues will be highlighted in discussion.

The interviewer will conform to the Ethical Guidelines of the UKCC for Nurses in interacting with individuals still receiving professional care.

5/ Exclusion: No subjects will be sought who are formally detained under the terms of The Mental Health Act 1983 or who appear uncertain and anxious about proceeding. Interviews will be carried out only with the express agreement of the Responsible Medical Officer and/or General Practitioner as well as key mental health workers such as Community Psychiatric Nurses and any other significant others such as Next-of-kin or Advocates. If distress is encountered at any stage during interview, the process will be stopped immediately and any appropriate individuals informed. Any record will be destroyed.

Consent Forms: The subjects will be asked to sign a consent form if agreement is reached.

A joint consent form will be used where appropriate to include significant others. Responsible Medical Officers including Consultants and General Practitioners will be asked to sign a consent form.

Participants letter.

Telephone number: ---------- --/--/200-

Dear,

I am a retired mental health nurse. I will tell you a little about myself before moving on to the reason you have been given this letter.

I am involved as a volunteer with services for mental health. I sit on a panel of three when patients wish to appeal against being detained or have their "sections" renewed. The formal title of this job is Hospital Manager for Mental Health Act Appeals. This job is totally independent of that of day-to-day service managers and has a strong role in defending the rights of patients. I can provide you with more information about this post if you wish.

I am also currently working towards a degree of Doctor of Philosophy at De Montfort University in Leicester, while teaching part-time. There is no link between the work for the degree and the work described above. Both remain confidential and no information is shared between the two.

The reason you have been given this letter is to ask you to participate in the research study for the degree. The study is based on an exploration of how the idea of "community" was viewed in mental health terms in the past and in particular during the period before 1965 when most care was in hospital. A lot of the research so far has consisted of life history interviews.

Although I have been able to interview a number of ex staff including doctors and nurses who worked locally at this time, the material contributed by ex patients has been from the National Sound Archive and none has been from Northamptonshire people. It is felt to be important to include the experiences of those who were patients in St Crispin Hospital before 1965 in the research.

The research would consist of a one to one interview with me that I would like to record in sound only. It would consist of questions describing your life including periods in hospital. It would only be carried out after your full, written consent. There is an attached document describing the work in more detail.

The recording would be confidential, kept securely and only used under conditions specified by you. You would not be identified by name during any use of the material. You would receive a written account of the interview to look at and approve before any use is made of the recording.

The study is voluntary and whether or not you choose to take part will not affect your care in any way. If you agree to take part or are just interested, I will come and see you to explain in more depth. I can be contacted either through a member of staff or at the telephone number above.

PTO

Material on your rights regarding any recorded Oral History for you to read, if you wish, is also attached.
Thank you for your help in this matter.

Yours Sincerely,

Rod Griffin

Participant Information Sheet.

If you have any concerns about this study and wish to discuss it with someone who is independent, please contact Mr G---- S----- C/o Northamptonshire Local Research/Ethics Committee, (01604) 615363

Research Title: Concepts of Community in Mental Health 1935 to 1965

You are being invited to participate in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully. Please feel free to ask, if there is anything that is not clear, or if you would like more information. You will find a contact telephone number at the end of this sheet and may call at any time.

What is the research about?
The research is being done to explore the history of how the nature of community in relation to mental health services has been understood over time. Today we live in a time of "care in the community". In the middle of the last century, most care was hospital based, as you are aware.

In the span of time of approximately thirty years between the mid nineteen thirties and mid nineteen sixties many changes took place. By the nineteen sixties, moves towards a different form of care were advancing.

It is hoped that the study will help to develop a theoretical understanding of some of the processes that have taken place over time in forming meanings of the term "community".

Why have I been chosen?
You have been approached because you knew hospital life as a patient at some time during those years and experienced some of those changes. A number of ex-staff and others are contributing already. It is felt to be very important that the recollections and views of ex-patients are included too.

Who is involved in the Research?
The research is being carried out by Rod Griffin who is studying for a PhD (Doctor of Philosophy) at the Faculty of Health and Community Studies of De Montfort University, Scraptoft, Leicester. He will be carrying out all of the interviews. The approach to you is being carried out with the knowledge and agreement of your Consultant, GP and other care staff. They have agreed that you may be asked if you wish to take part.

Do I have to take part?
No, the study is entirely voluntary. Whether you choose to take part or not, this will not effect your care in any way. If you decide to take part, you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, you are still free to withdraw from the study at any time. You do not need to give a reason to withdraw.

What is involved?
If you are willing, the researcher will visit you and explain in more detail about an interview he would like to do with you. The meeting will be at a time and place convenient to you. You may have another person of your choice present with you if you wish.

The researcher will show you some documents and go through them with you. They will detail you rights regarding any material arising from an interview if you agree. These will include copies of the guidelines of the legal requirements and general guidelines outlined in the Code of Ethics of the Oral History Society. The researcher is a member of the Oral History Society. The Statement of Ethical Practice within The British Sociological Association Guidelines will be followed in the research and a copy will be given to you to read if you wish. Information on copyright and any other relevant issues will be highlighted in discussion.

What you are being asked to do is a tape-recorded history of memories of your background and experiences with the mental health services in the nineteen sixties or before. It will be done in the form of an interview with the researcher asking you questions. It is recognised that memories fade with time and you should not worry if you cannot recall too many things.

After the first visit, the researcher will leave you for a period of about a week to decide if you wish to go ahead. This will give you time to think and perhaps discuss with others if you wish.

You will then be contacted again. This may be by telephone or by another visit if you prefer. If you then agree to be interviewed, you will be visited again at a time and place of your convenience and with another person of your choice present if you wish. You will be asked to sign a consent form.

Note: Your Consultant and/or General Practitioner as well as others who work closely with you will have already been contacted and asked to sign consent forms to agree to you being approached for interview. This has been done to help protect your interests. It will not mean that although they have been contacted first you are under any obligation to be interviewed if you do not wish.

If you are willing, the interview will take place. The fact that you have signed a consent form does not mean that you may not still withdraw at any time.

When the interview is complete, the tape recording will be typed out. You will receive a copy and given as long as you wish to read it through. The researcher will then visit you again. You will be able to say if you are happy with the recording. If you are not, you can say you do not wish it to be used for the research and ask that it be destroyed. Or you could ask for particular pieces not to be used in the research. You would also be able to make suggestions or clarify any points that you wish. It will be totally up to you.

What happens to the information?
As you read in the last paragraph, that will be up to you. All the information will be confidential. No one should be able to identify you from the study. The only

possibility of this happening is if someone who knew you remembers you from a situation you may describe in the interview. If there is a possibility of this, it should be identified before such information is used and included in the study report. No individuals will be named in transcriptions and/or written reports. Tapes will be marked only by a code letter and the names of the individuals will be kept in a separate notebook. Tapes, transcripts and the coded identification notebook will be kept separately, in a locked secure environment. Control of the information derived from the interviews will conform to the current Data Protection Act. You will decide what ultimately happens to the tapes after the research is over. You may wish them to be destroyed for example, given to relatives or placed in an oral history archive such as that at The British Library. You will be able to write your wishes on the "restrictions" space your consent form.

The interviewer, as a registered nurse will also conform to the Ethical Guidelines of the UKCC for Nurses in interacting with individuals still receiving professional care.

What if I wish to complain?
If you wish to complain you may speak to anyone involved in your care, friends, relatives or advocates. If you wish to complain direct, please contact the researchers supervisor Dr Simon Dyson of De Montfort University, Leicester (Telephone 0116 257 7751 - 8am - 4pm weekdays).

What will happen to the results of the research?
The results of the research will be incorporated into a thesis. No individuals will be mentioned by name in the thesis. The thesis will be made available to anyone who requests to read it including you.

Contact Number: For further information about the research please contact Rod Griffin: Telephone ----------.

Thank you for taking the time to read this information sheet and considering participation in this study.

Rod Griffin
Student Reference Number: DMU P9712689X

Letter to GP.

Dear Colleague,

I am writing to inform you that I would like to approach your patient ------ ------ of ------to participate in a research study. The project relates to an exploration of the origins of concepts of care in the community. This includes, the use of life history interviews with individuals who have experienced mental health problems leading to admission at St Crispin Hospital in the period leading up to 1965. The research is for a PhD from De Montfort University and is a development of earlier work for an MA.

As part of the research design, I have so far used oral life history interviews from medical, nursing and other staff associated with St Crispin Hospital. Oral life histories of ex-patients have however been available only from the National Sound Archive of The British Library and have not therefore been of local individuals. This has left a deficit in terms of recording the experiences of those who used services in Northampton at this time and in particular those who were admitted to St Crispin Hospital.

I am aware of the vulnerability of the ageing group I am hoping to access. Participation would be voluntary and fully informed consent will be sought. The research will be confidential and no one will be identified by name if volunteers are obtained.

I am proposing to access any appropriate individuals by way of current mental health services and am seeking your support in this matter. Ethics Committee approval from both the NHS Trust and De Montfort University have been obtained. I will not approach any individual under your care without first contacting you and with the approval of the currently responsible service providers.

I enclose information on the Oral History Method and the research protocol.

Thank you for your attention.

Yours sincerely,

R. J Griffin.

Letter to Consultants.

Dear Colleague,

I am writing to you requesting permission to develop a research project by approaching clients under your care.

The project relates to a theoretical exploration of the origins of concepts of community in mental health between 1935 and 1965. The methodology includes the use of life history interviews with individuals who experienced mental health problems leading to admission to hospital during this period. The research is for a PhD from De Montfort University and is a development of earlier work for an MA.

As part of the research design, I have so far used oral life history interviews from medical, nursing and other staff associated with St Crispin Hospital. Oral life histories of ex-patients have however been accessed only from the National Sound Archive of the British Library and have not therefore been of local individuals and those who were admitted to St Crispin Hospital in particular.

I am aware of the vulnerability of the ageing group I am hoping to access. Participation would be voluntary and fully informed consent will be sought. The research will be confidential and no one will be identified by name if volunteers are obtained.
I am proposing to access any appropriate individuals by way of current mental health services and am therefore seeking your consent in this matter.

I enclose a summary of the research protocol that has been approved by De Montfort University Ethics Committee and Northamptonshire Research and Ethics Committee. Please contact me if you would like to see more of the research materials or ask questions.

I will not approach any individual under your care without first contacting you, the patients GP and with the approval of any other currently responsible service providers, relatives or other significant individuals.

I would like to formally request permission from you, as a consultant in the Northamptonshire Community NHS Trust, to allow an approach to be made to patients who fit the criteria with a view to seeking their permission to interview. I enclose a consent form and if you agree, I would ask you to sign this form and return it to me as soon as possible in the envelope provided.

Thank you for your attention.

Yours sincerely,

R. J. Griffin.

Letter to GP confirming that their patient will be interviewed after permission has been previously sought using documentation already submitted.

Dear Colleague,

Research Project: Concepts of Community in Mental Health 1935 to 1965

I am writing to confirm that I will be interviewing your patient ----(Name)---- as previously agreed by you on the consent form dated (---Date----), as part of the above research project. I would like to thank you for your co-operation in this matter.

Yours sincerely,

R. J. Griffin

Joint Consent Form.

De Montfort University,
Scraptoft,
Leicester.

Study Title: Concepts of Community in Mental Health 1935 to 1965
Name of Researcher: Rod Griffin: PhD Student
Name of patient or client _____
Address

I confirm that I have read and understand the information sheet dated November 2002 for the above study and have had the opportunity to ask questions.

I understand that my _____ (e.g. patients, clients, relatives) participation is voluntary and that he/she is free to withdraw at any time, without giving any reason, without his/her medical care or legal rights being affected.

I agree to audio-recording of an oral history interview of my _____by a researcher as part of the above study.

Name of patient	Date	Signature
Name of consenting individual and relationship to interviewee	Date	Signature
Name of person witnessing consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

(1 for patient; 1 for researcher; 1 for joint consenting individual)

Interviewee Consent Form.

De Montfort University
Scraptoft
Leicester

Study Title: Concepts of Community in Mental Health 1935 to 1965
Name of Researcher: Rod Griffin: PhD Student.

I confirm that I have read and understand the information sheet dated November 2002 for the above study and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand my medical and legal rights will not be affected.

I consent to this taped history of elements of my personal background and in particular my experiences as a patient using services for the mentally ill in the period leading up to the mid nineteen sixties.

This release is subject to approval of a transcription of the interview, which has been made available to me and any restrictions outlined below.
RESTRICTIONS

_____

_____

_____

_____

Narrator_____Date_____Signature_____
Address _____

_____

_____

_____

_____

Witness to Consent _____Date_____Signature_____
(I.e. researcher, consultant, careworker, relative, friend, advocate)

Adap.RJG/11/2002

Northampton NHS
Primary Care Trust

Northamptonshire Local Research/Ethics Committee
Chairman: Dr Robin Sheppard
Administrative Assistant: Mrs Michelle Koornhof ☎(01604) 615363

Our Ref:03/67
29 August 2003

Mr R Griffin
149 Boughton Green Road
Kingsthorpe
Northampton
NN2 7AA

Dear Mr Griffin

Re: 03/67 Concepts of community in mental health 1935 to 1965

The Northamptonshire Local Research/Ethics Committee reviewed your amendments to the above application at their meeting on 29 August 2003. The documents reviewed were as follows:-

- **Letter to the Committee from Mr Griffin dated August 2003**
- **Protocol**
- **Question guidelines**
- **Patient Information Sheet**

The Committee is prepared to offer a favourable opinion to the application subject to the submission of the following information and/or amendments, which are detailed below:-

- **Confirmation to be received that once a study participant had been identified a letter be sent to the appropriate GP informing him/her of their patients inclusion in the study.**
- **Confirmation to be received that a transcript of the tape recording is to be approved by the study participant before any information is taken from it.**

The Committee has delegated authority to the Chairman to agree these amendments once they have been received. Subject to the Chairman's agreement, a formal letter offering a favourable opinion will then be issued.

When submitting the response to the Committee, please send revised documents where appropriate and underlining the changes you have made and giving revised version numbers and dates.

Yours sincerely

Dr Robin Sheppard
Chairman of the Northamptonshire Local Research/Ethics Committee

Northamptonshire Local Research/Ethics Committee
Highfield,
Cliftonville Road,
Northampton.
NN1 5DN

Ref: 03/67

Response to Northamptonshire Local Research/Ethics Committee Application for approval – Concepts of Community in Mental Health 1935 to 1965

Dear Dr Sheppard,

Thank you for your letter in relation to the review of amendments to my application at your meeting on 29th August 2003.

1/ I confirm that once a study participant has been identified, a letter will be sent to the appropriate GP informing him/her of their patients inclusion in the study. (Please see attached document.) This will of course follow their approval of the initial approach. The consent form for a GP has already been submitted to the committee.

2/ I confirm that a transcript of the tape recording will be approved by the study participant before any information is taken from it.

Many thanks for your help.

Yours sincerely

R. J. Griffin

COPYRIGHT AND ORAL HISTORY

by Alan Ward

Introduction

This short guide is for people who record oral history interviews, and organisations and individuals who keep collections of oral history recordings in the United Kingdom.

The rights established by law enable copyright holders to license the copying, distribution and performance of their "intellectual property" (including written or recorded words, musical compositions, sound and video recordings etc.) in return for payment. This is one of the main sources of income supporting authors, composers, publishers and record companies, not to mention the thousands of lawyers and executives who run the large international organisations which negotiate and distribute copyright payments.

However, individual interviewers and interviewees involved in oral history work cannot normally expect payment if their words or recordings are copied or distributed, and they cannot normally afford to sue those who infringe their rights. Partly for this reason, most are willing to transfer recordings and assign their rights to custodians such as sound archives, museums, or local history collections in libraries, because these bodies are generally able to prevent the abuse and unauthorised copying of interview material, while providing suitable facilities for proper use. The Society strongly supports this and can give advice about suitable local places of deposit (some of which are members of the Society's Regional Network). In this context therefore, copyright law provides a rather cumbersome framework for the transfer of rights to trustworthy custodians. In return, the custodians obtain permission to make responsible use of interviews, for example by making them available for research or for educational use.

Copyright law covers many kinds of intellectual property and is quite complicated. Many people find it difficult to understand, so an attempt has been made below to summarise in straightforward terms those parts of the current law which relate to oral history. In doing this some details and exceptions have been omitted. Those wishing to extend their knowledge should refer initially to the current Copyright Act (1988) which, unlike the 1956 Act, is quite clearly laid out and generally straightforward. Other useful reading about copyright and ethics is listed at the end.

It is important for custodians and collectors of oral history interview recordings to obtain "copyright clearance" from interviewees and recordists when the recordings are deposited. This is best done using a standard form of which an example appears later. Retrospective clearance is usually very time-consuming and often impossible if informants or recordists have died or moved away. Recordings which have not been cleared cannot be used legally for many purposes and the point of keeping them is largely defeated. However, in order to retain the trust of their informants and collaborators, without whose unpaid help most oral history work could not take place, custodians must act ethically as well as legally. Copyright law gives some protection to the "moral rights" of informants even after copyright has been transferred, but again very few are in a position to enforce these rights.

The Oral History Society has therefore agreed ethical guidelines which cover responsibilities and obligations beyond legal requirements. Custodians and places of deposit which the Society is prepared to recommend have agreed to abide by these guidelines.

Ownership of copyright

When an interview is recorded, separate copyrights in

the words spoken

the recording

are created. There is no requirement under British law for copyright to be registered in some way, or for copyright material to be marked as such. Initially the owner of the copyright in the words is the speaker, while the copyright in the recording belongs to the person or organisation which arranged for the recording to be made. Recordists working as individuals own the copyright in their recordings, but where the recordist is employed by someone else, the employer owns the copyright.

Copyright in written transcripts of interviews, made either verbatim or subsequently from recordings, is best regarded as belonging to the owner of the copyright in the words transcribed.

Copyright is a form of property and may be "assigned" or bequeathed to some other person or to an organisation. Assignments need to be in writing and signed by the copyright owner. Assignments can be made subject to conditions (for example limitations on access or use).

Duration of copyright

(i) Recorded speech

Under the 1988 Act, copyright expires 50 years from the end of the year in which the speaker dies, continuing long-standing British practice. However from July 1995 copyright duration was harmonised throughout the European Union and extended to expire 70 years from the end of the year in which the speaker dies.

(ii) Sound and video recordings

Under the 1988 Act, copyright expires at the end of 50 years from the end of the year in which the recordings were made, unless the recordings are published or broadcast, in which case copyright expires fifty years from the end of the year of publication or first broadcast, Thus if a recording was made in 1993, copyright in it will expire on 31

December 2043, unless it is, say, published in 2010, in which case copyright will expire on 31 December 2060.
Copyright in unpublished sound recordings made during the currency of the 1956 Copyright Act (1957-89) expires at the end of 2039 (50 years following the date when the 1988 Act came into force) . If such recordings are or have been published within this period, copyright expires at the end of 50 years following the date of publication.

The scope of copyright

Recorded speech and recordings which are "in copyright" may not be copied, "issued to the public", performed or played in public, adapted or broadcast without the copyright owner's permission.
There are some "fair dealing" concessions which allow the recorded content of oral history interviews to be copied for private study, research, criticism or review. Short extracts may be used as illustrative matter in publications; libraries and archives are allowed to make copies for preservation purposes; and educational establishments may, subject to various limitations, make copies for instructional purposes. Unfortunately owing to a serious defect in the 1988 Act, similar concessions do not apply to the separate copyright in the recording.
So the recording copyright owner's permission is required if any copying of any sort is envisaged.

Moral rights

Under the 1988 Act oral history interviewees have a right to be named as the "authors" of their recorded words if they are published or broadcast, and publishers and broadcasters are obliged not to subject their words to "derogatory treatment" by, for example, editing, adapting or making alterations which create a false impression

Practical steps

Oral history interviewers, and bodies such as local history societies or museums which organise interviewing projects, should ask their interviewees to assign copyright to them by completing and signing a clearance form. The purpose of the assignment is to enable routine consultation of interviews to take place as agreed with interviewees (subject to any restrictions they may wish to impose) and to enable parts of recorded interviews or extracts from transcriptions to be used in publications, broadcasts etc. The possession of copyright does not absolve recordists or custodians from the duty to inform or consult interviewees when their words may be published or broadcast - the Society's ethical guidelines provide that such consultation should take place whatever the copyright position but as time goes on it may become difficult to contact interviewees or their friends, relatives or heirs, and without the signed clearance form, publication or other beneficial uses may be prevented.

EXAMPLE OF CLEARANCE AND COPYRIGHT FORM

British Library
National Sound Archive
29 Exhibition Road
London SW7 2AS

CLEARANCE NOTE AND DEPOSIT INSTRUCTIONS

The purpose of this deposit agreement is to ensure that your contribution is added to the collections of the British Library National Sound Archive in strict accordance with your wishes. All material will be preserved as a permanent public reference resource for use in research, publication, education, lectures and broadcasting.

If you wish to limit public access to your contribution for a period of years (up to a maximum of 30 years) please state these conditions:

I hereby assign the copyright in my contribution to the British Library National Sound Archive.

Signed _____ Date _____

Address _____

Signed (NSA) _____ Date _____

Office use only:

Full name: _____

Acc. no: _____ Playback no: _____

Series title: _____

Custodians should also obtain written assignments of any copyrights held by individual recordists. Where recordists have not obtained an assignment of copyright from their informants, the future usefulness and value of the recordings may not justify the time and effort needed to conserve and document them. Most custodians will not have the resources to make retrospective contact with informants, who may by this stage be scattered far and wide, if they are still living. Except for the *fair dealing* provisions, the Copyright Act provides no mechanism through which copyright interviews or recordings may be used without permission, for instance in cases where the copyright owners cannot be traced.

provide an irksome aspect of interviewing, it ensures that informants purpose of the interview and its future use, and may help to avoid ndesirable uses, apart from the formal copyright requirement. anised and financed the recording of interviews will already own the m, so only the interviewees' rights need to be cleared.

Clearance forms currently in use follow a standard pattern such as in the one illustrated. The only variation tends to be in the range of options (if any) offered to interviewees. Some custodians need, for instance, to enable interviewees to remain anonymous, to place restrictions on the types of use to which the recordings may be put, or to prevent consultation before a certain date. Such options can be included on the form with boxes to tick, or can be added in writing. Practical experience indicates that restrictions of this sort often serve little purpose except to make extra work, but they may be appropriate or even essential when interviews contain personal references.

Further reading

Copyright, Designs and Patents Act 1988, HMSO, 1988.

Alan Bruford et al., "My tongue is my ain", Phonographic Bulletin, 57 (1990).

Theodore Karamanski, Ethics and public history: an anthology, Malabar: Krieger Publishing, 1990. An American collection of articles on ethical issues.

National Oral History Association of New Zealand, Code of ethical and

technical practice, NOHANZ: nd.
John Neuenschwander, Oral history and the law, Albuquerque: Oral History Association, revised edition 1993. This provides a useful comparison by describing the position in the US.
Oral History Association [USA], Oral history evaluation guidelines, New York: OHA, 1980 (and amendments).
Daphne Patai, "Ethical problems of personal narratives, or, who should eat the last piece of cake?", International Journal of Oral History, 8 (Feb. 198 7). A clear discussion of the ethics of oral history in the US.
J.B. Post and M.R. Foster, Copyright. A handbook for archivists, Society of Archivists, 1992.
Alan Ward, Manual of sound archive administration, ,Gower, 1990. Includes a chapter on copyright considerations.
Valerie Raleigh Yow, Recording oral history: a practical guide for social scientists, Sage, 1994. An excellent guide which includes a useful chapter on ethical issues.
Information leaflets on various aspects of copyright are published by the Library Association, 7 Ridgemount Street, London WC I E 7AE and by the National Council for Educational Technology, Milburn Hill Road, Science Park, Coventry CV4 7JJ

Go on to Ethical Guidelines
Home Page | Regional Network | Conferences | Resources | Journal
Join Now | Practical Advice | Training | Copyright & Ethics | Funding

Statement of Ethical Practice of the British Sociological Association

The British Sociological Association gratefully acknowledges the use made of the ethical codes produced by the American Sociological Association, the Association of Social Anthropologists of the Commonwealth and the Social Research Association.

Styles of sociological work are diverse and subject to change, not least because sociologists work within a wide variety of settings. Sociologists, in carrying out their work, inevitably face ethical, and sometimes legal, dilemmas which arise out of competing obligations and conflicts of interest. The following statement aims to alert the members of the Association to issues that raise ethical concerns and to indicate potential problems and conflicts of interest that might arise in the course of their professional activities.

While they are not exhaustive, the statement points to a set of obligations to which members should normally adhere as principles for guiding their conduct. Departures from the principles should be the result of deliberation and not ignorance. The strength of this statement and its binding force rest ultimately on active discussion, reflection, and continued use by sociologists. In addition, the statement will help to communicate the professional position of sociologists to others, especially those involved in or affected by the activities of sociologists.

The statement is meant, primarily, to inform members' ethical judgements rather than to impose on them an external set of standards. The purpose is to make members aware of the ethical issues that may arise in their work, and to encourage them to educate themselves and their colleagues to behave ethically. The statement does not, therefore, provide a set of recipes for resolving ethical choices or dilemmas, but recognises that often it will be necessary to make such choices on the basis of principles and values, and the interests of those involved.

At its meeting in July 1994, the BSA Executive Committee approved a set of Rules for the Conduct of Enquiries into Complaints against BSA members under the auspices of this Statement, and also under the auspices of the BSA Guidelines on Professional Conduct. If you would like more details about the Rules, you should contact the BSA Office at the address/phone number given at the end of this statement.

Professional Integrity

Members should strive to maintain the integrity of sociological enquiry as a discipline, the freedom to research and study, and to publish and promote the results of sociological research. Members have a responsibility both to safeguard the proper interests of those involved in or affected by their work, and to report their findings accurately and truthfully. They need to consider the effects of their involvements and the consequences of their work or its misuse for those they study and other interested parties.

While recognising that training and skill are necessary to the conduct of social research, members should themselves recognise the boundaries of their professional competence. They should not accept work of a kind that they are not qualified to

carry out. Members should satisfy themselves that the research they undertake is worthwhile and that the techniques proposed are appropriate. They should be clear about the limits of their detachment from and involvement in their areas of study.

Members should be careful not to claim an expertise in areas outside those that would be recognised academically as their true fields of expertise. Particularly in their relations with the media, members should have regard for the reputation of the discipline and refrain from offering expert commentaries in a form that would appear to give credence to material which as researchers they would regard as comprising inadequate or tendentious evidence.

Relations With And Responsibilities Towards Research Participants

Sociologists, when they carry out research, enter into personal and moral relationships with those they study, be they individuals, households, social groups or corporate entities. Although sociologists, like other researchers are committed to the advancement of knowledge, that goal does not, of itself, provide an entitlement to override the rights of others. Members must satisfy themselves that a study is necessary for the furtherance of knowledge before embarking upon it. Members should be aware that they have some responsibility for the use to which their research may be put. Discharging that responsibility may on occasion be difficult, especially in situations of social conflict, competing social interests or where there is unanticipated misuse of the research by third parties.

1. Relationships with research participants

a. Sociologists have a responsibility to ensure that the physical, social and psychological well-being of research participants is not adversely affected by the research. They should strive to protect the rights of those they study, their interests, sensitivities and privacy, while recognising the difficulty of balancing potentially conflicting interests. Because sociologists study the relatively powerless as well as those more powerful than themselves, research relationships are frequently characterised by disparities of power and status. Despite this, research relationships should be characterised, whenever possible, by trust. In some cases, where the public interest dictates otherwise and particularly where power is being abused, obligations of trust and protection may weigh less heavily. Nevertheless, these obligations should not be discarded lightly.

b. As far as possible sociological research should be based on the freely given informed consent of those studied. This implies a responsibility on the sociologist to explain as fully as possible, and in terms meaningful to participants, what the research is about, who is undertaking and financing it, why it is being undertaken, and how it is to be promoted.

i. Research participants should be aware of their right to refuse participation whenever and for whatever reason they wish. They should also not be under the impression that they are required to participate.

ii. Research participants should understand how far they will be afforded anonymity and confidentiality and should be able to reject the use of data-gathering devices such as tape recorders and video cameras.

i. Where there is a likelihood that data may be shared with other researchers, the potential uses to which the data might be put may need to be discussed with research participants.
ii. When filming or recording for research purposes, sociologists should make clear to research participants the purpose of the filming or recording, and, as precisely as possible, to whom it will be communicated. Sociologists should be careful, on the one hand, not to give unrealistic guarantees of confidentiality and, on the other, not to permit communication of research films or records to audiences other than those to which the research participants have agreed.
iii. It should also be borne in mind that in some research contexts, especially those involving field research, it may be necessary for the obtaining of consent to be regarded, not as a once-and-for-all prior event, but as a process, subject to renegotiation over time. In addition, particular care may need to be taken during periods of prolonged fieldwork where it is easy for research participants to forget that they are being studied.
iv. In some situations access to a research setting is gained via a 'gatekeeper'. In these situations members should adhere to the principle of obtaining informed consent directly from the research participants to whom access is required, while at the same time taking account of the gatekeepers' interest. Since the relationship between the research participant and the gatekeeper will continue long after the sociologist has left the research setting, care should be taken not to inadvertently disturb that relationship unduly.

a. It is incumbent upon members to be aware of the possible consequences of their work. Wherever possible they should attempt to anticipate, and to guard against, consequences for research participants which can be predicted to be harmful. Members are not absolved from this responsibility by the consent given by research participants.

b. In many of its guises, social research intrudes into the lives of those studied. While some participants in sociological research may find the experience a positive and welcome one, for others, the experience may be disturbing. Even if not exposed to harm, those studied may feel wronged by aspects of the research process. This can be particularly so if they perceive apparent intrusions into their private and personal worlds, or where research gives rise to false hopes, uncalled for self-knowledge, or unnecessary anxiety. Members should consider carefully the possibility that the research experience may be a disturbing one and, normally, should attempt to minimise disturbance to those participating in research. It should be borne in mind that decisions made on the basis of research may have effects on individuals as members of a group, even if individual research participants are protected by confidentiality and anonymity.

c. Special care should be taken where research participants are particularly vulnerable by virtue of factors such as age, social status and powerlessness. Where research participants are ill or too young or too old to participate, proxies may need to be used in order to gather data. In these situations care should be taken not to intrude on the personal space of the person to whom the data ultimately refer, or to disturb the relationship between this person and the proxy. Where it can be inferred that the person about whom data are sought would object to supplying certain kinds of information, that material should not be sought from the proxy.

2. Covert Research

There are serious ethical dangers in the use of covert research but covert methods may avoid certain problems. For instance, difficulties arise when research participants change their behaviour because they know they are being studied. Researchers may also face problems when access to spheres of social life is closed to social scientists by powerful or secretive interests. However, covert methods violate the principles of informed consent and may invade the privacy of those being studied. Participant or non-participant observation in non-public spaces or experimental manipulation of research participants without their knowledge should be resorted to only where it is impossible to use other methods to obtain essential data. In such studies it is important to safeguard the anonymity of research participants. Ideally, where informed consent has not been obtained prior to the research it should be obtained post-hoc.

3. Anonymity, privacy and confidentiality

a. The anonymity and privacy of those who participate in the research process should be respected. Personal information concerning research participants should be kept confidential. In some cases it may be necessary to decide whether it is proper or appropriate even to record certain kinds of sensitive information.

b. Where possible, threats to the confidentiality and anonymity of research data should be anticipated by researchers. The identities and research records of those participating in research should be kept confidential whether or not an explicit pledge of confidentiality has been given. Appropriate measures should be taken to store research data in a secure manner. Members should have regard to their obligations under the Data Protection Act. Where appropriate and practicable, methods for preserving the privacy of data should be used. These may include the removal of identifiers, the use of pseudonyms and other technical means for breaking the link between data and identifiable individuals such as 'broadbanding' or micro-aggregation. Members should also take care to prevent data being published or released in a form which would permit the actual or potential identification of research participants. Potential informants and research participants, especially those possessing a combination of attributes which make them readily identifiable, may need to be reminded that it can be difficult to disguise their identity without introducing an unacceptably large measure of distortion into the data.

c. Guarantees of confidentiality and anonymity given to research participants must be honoured, unless there are clear and overriding reasons to do otherwise. Other people, such as colleagues, research staff or other employees, given access to the data must also be made aware of their obligations in this respect. By the same token, sociologists should respect the efforts taken by other researchers to maintain anonymity. Research data given in confidence do not enjoy legal privilege, that is they may be liable to subpoena by a court. Research participants may also need to be made aware that it may not be possible to avoid legal threats to the privacy of the data.

d. There may be less compelling grounds for extending guarantees of privacy or confidentiality to public organisations, collectivities, governments, officials or agencies than to individuals or small groups. Nevertheless, where guarantees have

been given they should be honoured, unless there are clear and compelling reasons not to do so.

4. Relations With & Responsibilities Towards Sponsors And/Or Funders

During their research members should avoid, where they can, actions which may have deleterious consequences for sociologists who come after them or which might undermine the reputation of sociology as a discipline.

A common interest exists between sponsor, funder and sociologist as long as the aim of the social inquiry is to advance knowledge, although such knowledge may only be of limited benefit to the sponsor and the funder. That relationship is best served if the atmosphere is conducive to high professional standards. Members should attempt to ensure that sponsors and/or funders appreciate the obligations that sociologists have not only to them, but also to society at large, research participants and professional colleagues and the sociological community. The relationship between sponsors or funders and social researchers should be such as to enable social inquiry to be undertaken as objectively as possible. Research should be undertaken with a view to providing information or explanation rather than being constrained to reach particular conclusions or prescribe particular courses of action.

Clarifying obligations, roles and rights

a. Members should clarify in advance the respective obligations of funders and researchers where possible in the form of a written contract. They should refer the sponsor or funder to the relevant parts of the professional code to which they adhere. Members should also be careful not to promise or imply acceptance of conditions which are contrary to their professional ethics or competing commitments. Where some or all of those involved in the research are also acting as sponsors and/or funders of research the potential for conflict between the different roles and interests should also be made clear to them.

b. Members should also recognise their own general or specific obligations to the sponsors whether contractually defined or only the subject of informal and often unwritten agreements. They should be honest and candid about their qualifications and expertise, the limitations, advantages and disadvantages of the various methods of analysis and data, and acknowledge the necessity for discretion with confidential information obtained from sponsors. They should also try not to conceal factors which are likely to affect satisfactory conditions or the completion of a proposed research project or contract.

Pre-empting outcomes and negotiations about research

a. Members should not accept contractual conditions that are contingent upon a particular outcome or set of findings from a proposed inquiry. A conflict of obligations may also occur if the funder requires particular methods to be used.

b. Members should try to clarify, before signing the contract, that they are entitled to be able to disclose the source of their funds, its personnel, the aims of the institution, and the purposes of the project.

c. Members should also try to clarify their right to publish and spread the results of their research.
Members should be prepared to clarify with sponsors the methods of analysis to be used.

Guarding privileged information and negotiating problematic sponsorship

a. Members are frequently furnished with information by the funder who may legitimately require it to be kept confidential. Methods and procedures that have been utilised to produce published data should not, however, be kept confidential.

b. When negotiating sponsorships members should be aware of the requirements of the law with respect to the ownership of and rights of access to data.

c. In some political, social and cultural contexts some sources of funding and sponsorship may be contentious. Candour and frankness about the source of funding may create problems of access or co-operation for the social researcher but concealment may have serious consequences for colleagues, the discipline and research participants. The emphasis should be on maximum openness.

d. Where sponsors and funders also act directly or indirectly as gatekeepers and control access to participants, researchers should not devolve their responsibility to protect the participants' interests onto the gatekeeper. Members should be wary of inadvertently disturbing the relationship between participants and gatekeepers since that will continue long after the researcher has left.

Obligations to sponsors and/or Funders During the Research Process

a. Members have a responsibility to notify the sponsor and/or funder of any proposed departure from the terms of reference of the proposed change in the nature of the contracted research.

b. A research study should not be undertaken on the basis of resources known from the start to be inadequate, whether the work is of a sociological or inter-disciplinary kind.

c. When financial support or sponsorship has been accepted, members must make every reasonable effort to complete the proposed research on schedule, including reports to the funding source.

d. Members should be prepared to take comments from sponsors or funders or research participants.

e. Members should, wherever possible, spread their research findings.

f. Members should normally avoid restrictions on their freedom to publish or otherwise broadcast research findings.

Advance approval of activities involving human research ethics

Review of activity
Has the research proposal identified any of the following research procedures?

1. Gathering information about human beings through; Interviewing, Surveying, Questionnaires, and Observation of human behaviour.

2. Using archived data in which individuals are identifiable.

3. Researching into illegal activities, activities at the margins of the law or activities that have a risk or injury.

If any of the above occur does the proposal satisfactorily identify the ways in which the researcher/student will be dealing with the following (tick boxes for 'YES').

- ☐ Providing participants with full details of the objectives of the research
- ☐ Voluntary participation with informed consent
- ☐ Written description of involvement
- ☐ Freedom to withdraw
- ☐ Keeping appropriate records
- ☐ Signed acknowledgement and understanding by participants
- ☐ Consideration of relevant codes of conduct

Do the procedures identified necessitate formal assessment? YES/NO
If so has the assessment been carried out? YES/NO

Other factors that could/will give rise to ethical concerns.

There are four possible outcomes from reviewing the activity against the three categories and the procedures in place:

1. No ethical issues

2. Minor ethical issues which have been addressed and concerns resolved

3. Major ethical issues which have been addressed and concerns resolved

4. Ethical issues that have not been resolved

Tick the outcome of the review 1 ☐ 2 ☐ 3 ☐ 4 ☐

Authorisation

- The reviewer authorises those activities in the first three outcomes
- Activities in the third outcome are reported for information only to the Faculty Committee

- Activities in the fourth outcome are submitted to the Faculty Committee for resolution.

Signature of researcher/student date

Signature of supervisor date

Authorising signature date

APPENDIX: TWO: First oral history interview guidelines for six nurses narrators in an earlier research project.

Oral History Interview Questions

Medium: Audio recording.

Introduction

State the name of the interviewer, the name (or pseudonym of the narrator), the date and then briefly the purpose of the interview, if there is a special relationship to the interviewee - state it. Check consent.

Stress the period to concentrate on.

Background

Informants year of birth, marital status, year of marriage, birthplace.

Q: How many brothers and sisters did you have? Birth order and spacing.

Q: What did your father do for an occupation? - If health related, explore and ask if it influenced the decision of future career for them. If so, how?

Q: Repeat for mother asking specifically what had been her occupation before children were born.

Q: If mother worked: who looked after the children while your mother was at work.

Q: Do you remember your grandparents, contact, impressions, knowledge about their occupation.

Education

Q: How old were you when you first went to school?

Q: what type of school was it? - board, private, church day boarding, boys, girls, mixed?

Q: What did you think about school?

Q: Did you enjoy academic school work, did you enjoy games and sport?

Q: How old were you when you left?

Beginning of Employment

Q: When did you first begin work?

Q: What sort of work did you do?

Q: How did you come to begin this type of work?

Q: Can you recall and describe the process of your selection?

Q: How was recruitment carried out at this time?

Q: In what capacity did you begin?

Q: What was your title?

Q: Did you wear a uniform and if so what was it like? What were your feelings about wearing a uniform?

Q: What inspired you to do this type of work? Did you have satisfaction and pride in the work that you did?

Organisation of work.

Q: In what area did you first work?

Q: What shift system did you work? How many hours? Did you do extra hours or any overtime?

Q: What sort of rate were you paid at when you first started?

Q: What sort of duties were you first expected to do?

Q: Where the things or events involving the work situation that stand out in your mind that you would like to talk about?

Q: At the time were you thinking at all about safety in the job? Were you given any instruction from management about this? Did you consider there to be any degree of risk and if so how was this issue discussed?

Training

Q: Did you have any prior training of special skills?

Q: How did you train? How long did it take? Who trained you? What periods did you train in?

Q: What books - methods were used in your training? What did you think about your training? Do you feel that it equipped you for the job? If not what did and how did you learn?

Q: Were there any exchanges with others on a local, regional or national basis in developing any exchange of ideas related to national training that you knew of?

Q: What basic qualification/qualifications did you end up with and how was it/they recognised?

Q: Can you recall how you felt about the work at this stage of your career? What did you like about it? Was there anything that worried you about it?

Q: Did you stay in one area or were you moved?

Q: What was your relationship with the charge nurses/ sisters? What was his/her main job? What was your relationship to him/her? The doctors and the medical superintendent - how often did you see them on the wards? Did you have any contact with them?

Q: Were the doctors trained specialists in psychiatry? Did you have SHO's and if so what sort of contact, if any, did you have with them?

Q: How might a typical shift have been experienced by you at this time?

Q: Was the influence of the doctors on what happened on the wards important? How do you feel that was?

Q: Was the influence of the nursing staff important? How do you feel that was?

Q: Do you recall if different disciplines worked well together or if there was any conflict of interest between them?

Q: Were there any significant others who had an influence on working practice? (probe - members of management committee, clergymen etc.)

Q: Did you work with women/men or have any contact with female/male patients?

Q: Did men or women work together on any tasks? Did women/men such as the matron/chief male nurse have any authority over men/women in the hospital?

Q: How did you obtain promotion in your career? How was this process for others? At the beginning, how did you see your career developing?

Q: Do you recall any feelings of co-operation or rivalry between different institutions.

Patient/staff relationships.

Q: How many beds were there at the hospital?

Q: Do you recall how many staff there were in the hospital roughly and how many worked on each shift?

Q: By what means did patients come to the hospital? (E.g. formally, informally)

Q: Do you recall any patients admitted as a result of trauma experienced during the war?

Q: Was there an assessment process for new patients or for those whose condition was deteriorating? Can you describe it?

Q: If there was not such a system, how were such patients treated?

Q: Was the approach different between those detained informally and formally? Did they go to different parts of the hospital?

Q: What were the arrangements for housing them like - during the day and during the night?

Q: How was activity on the wards organised? What sort of activity was there?

Q: Did the staff work on separate shifts? Did this influence the work in any way? (Inc. relationships between staff/staff - patients/staff?

Q: Were there major forms of therapeutic activities off the wards? If so what were they (e.g. Farm etc.)?

Q: Were these activities, in your view, beneficial or not?

Q: Did men and women both have access to the same activities? - Did they work together or separately?

Q: What were the major forms of treatment that you recall being employed at this time?

Q: Who prescribed and authorised them?

Q: Were they always present when they were carried out?

Q: Who supervised these treatments?

Q: How effective can you recall them as being? (E.g. chlorpromazine - introduction)

Q: Can you recall any interventions that were specifically those of nurses and didn't include the involvement or authorisation of another discipline?

Q: Did the patients have any route for the making of complaints?

Q: Do you believe that this route was effective?

Q: How important was security involving the patients at this time?

Q: How were you made aware of security issues?

Q: How was this security ensured? (Probe: locked doors, observation cards, exercise yards etc.)

Q: Was seclusion used as a form of intervention at this time? Do you recall it as being a regular occurrence? Can you describe its practice? Who authorised its use in each instance? Do you recall any alternative approaches to seclusion being considered/used?

Q: What was your view of seclusion at the time?

Q: How do you recall the main characteristics of the relationship between the patients and staff?

Q: Do you recall there being a hierarchy in the relationships between staff and staff, patients and staff, patients and patients?

Q: What were the main features of it?

Q: Do you feel this to have been beneficial, benign, harmful or a mixture?

Q: Can you recall any incidents that you witnessed that you were not happy about? How did you deal with this?

Q: Can you recall any instances of practice that you feel were good?

Q: If yes to either of the last two questions, how did these influence you?

Q: Was any contact maintained between staff arid those patients who were discharged?

Q: Were there joint social activities for men and women patients?

Q: Were these centrally organised or between wards?

Q: Were male and female patients allowed to socialise informally off the wards?

Q: If not - why not?

Q: Do you recall the introduction of any major changes effecting treatment and social activity in the hospital (e.g. the "open door policy")

Q: Who or what do you recall as being the main motivating force in introducing them?

Q: What were your feelings about such changes?

Q: Do you recall the feelings of other colleagues? Do you remember them as being welcomed or resisted or a mixture of both?

Q: Do you remember the introduction of the 1948 National Health Service?

Q: What were your feelings about this?

Q: Do you recall the effect of this on the institutions role (If any) and or those working in it?

Work Community

Q: What do you remember the relationship between the various departments in the hospital as being like?

Q: Were there members of the same families working in the hospital?

Q: Did you meet other nurses outside of work? Did you socialise with other non-hospital people outside of work?

Q: How were new staff coming into the hospital treated?

Q: Did other nationalities and members of ethnic minorities work at the hospital? Did they tend to work together or socialise together?

Q: Were the activities, work and social life of the hospital in any way self-contained?

Q: Were there social events or places in town that staff from the hospital went to regularly in these early years of your working life?

Q: Were there hospital sponsored social or sporting activities? Did men and women participate in them separately or together?

Q: Were men and women allowed to socialise outside of working hours?

Q: Did members of staff help each other out in both their work and social lives?

Q: Did you make particular friends in the hospital? Can you tell me how this happened?

Q: Do you recall any incidents of unfairness and unkindness towards others that you wish to talk about?

Q: Was your family life effected by the hours that you put in at the hospital and if so, how?

Q: If married - Did your spouse also work? - there? Did this effect a new way of getting work done in the home?

Q: Did religious activity play any part in the life of the hospital?

Q: Were religious minorities catered for in any way?

Labour relations.

Q: Were there any concessions that made an easier living?
Q: Would you describe the working environment as being disciplined?

Q: How were personal disagreements between nurses and their supervisors dealt with?

Q: Do you remember any complaints coming from staff working at ward level? If so, what do you feel were the main types of complaint?

Q: How did you yourself get along with supervisors and managers?

Q: Was there any talk of unionisation? What was management's reaction if there was? If not, why do you think unionisation did not take place?

Career progression

Q: If you were a returning veteran, did you go straight back to your job?

Q: Had you noticed any changes from when you left and if so how did they effect you - if at all?

Q: How did your career progress after the attainment of your qualification? - open ended resume.

Q: Did your previous experience in ward-based practice influence you in the introduction of change?

Q: Would you like to talk about this?

Q: Are there any other issues you would like to talk about or any topics you would like to expand on?

Conclusion.

Inform the interviewee that the issue of copyright will be discussed again during the return appointment after the transcript of the interview has been presented for scrutiny.

RJG/94
ADAPTED FROM:
Sources: Thompson P. (1988) and Yow V. R. (1994)

APPENDIX: THREE: An example of revised oral history interview guidelines.

Subject: Oral History – Member of the medical staff
Medium: Audio Recording.

The area of experience to concentrate on to be stressed as that of St Crispin Hospital.

A - Background

1. Informants year of birth, marital status, year of marriage, birthplace.

2. Brothers and sisters. Birth order and spacing.

3. Father's occupation? - If health related, explored and asked if it influenced the decision of future career or activity for the subject.

4. Mother's occupation. What her occupation had been before children were born. If health related, explored and asked if it influenced the decision of future career or activity for the subject.

5. If mother worked, who looked after the children while she was at work?

6. Grandparents - whether the subject remembered them. Contact, impressions, knowledge about their occupation. Was it medicine/nursing related?

B - Education.

1. How old the subjects were when they first went to school.

2. The type of school - whether it was boarding, private, church day boarding, boys, girls, mixed or of any other description.

3. What was thought about school? Whether it was enjoyed, disliked, generated neutral feelings or any other.

4. Whether academic schoolwork was enjoyed. Whether the subjects enjoyed games and sport. Whether they enjoyed both.

5. How old the subjects were when they left school.

C - Beginning of employment (if they were conventionally employed)

1. When the subjects first began work.

2. What type of work did they do?

C - Home and Family

1. Marriage?

2. What were and are the most important relationships in their life?

3. Were there children or other dependent relationships?

D - Medical Career

1. How they begin this type of work.

2. What inspired them to this type of involvement?

3. Recall and description the process of selection.

4. How recruitment was carried out at this time.

5. Nature of the type of work - Early/ Later. Capacity in which subjects began.

6. The title they were known by.

7. What inspired subjects to this type of career and psychiatry in particular? Satisfaction and pride in the work or other activity?

E - Organisation of work.

1. In what area the subjects first worked.

2. The number of hours. Was there a minimum number of hours?

3. The sort of duties they recall being first expected to do.

5. The type of relationship they recall with the staff/patients - early on.

6. Things or events involving the work situation that stand out in the minds of the subjects that they wished to talk about.

7. Safety in the work? Whether the subjects considered there to be any degree of risk - personal/professional and if so how this issue was discussed and approached.

F - Training (if any was received for the area of activity)

1. Was there any form of training or guidance from colleagues? Alternatively, did they develop ideas and a role as they went along?
2. How the subjects were introduced and guided.

3. What books - methods were used. What did they think about these? Whether they felt that it equipped them for the role. If not what did and how did they learn?

4. Any exchanges with other colleagues in other hospitals on a local, regional or national basis in developing any exchange of ideas that were known of.

5. How the subjects felt about their involvement. What they liked about it. Anything that worried them about it.

6. Subjects and whether they recalled tending to stay in one area of interest or if this was varied.

G - What impact did they feel they made on the hospital community?

1. What relationship did she and her colleagues have with the patients?
   a) Early on.
   b) As their presence in the hospital evolved.

2. Relationships with the other staff. E.g., what was the main job of the charge nurse or sister perceived as? The Doctors and the Medical Superintendent - what was their role perceived as? How often the subjects saw other staff in any environment. Contact of any sort with them?

3. Was the influence of the doctors on what happened on the wards important do they recall?

4. Was the influence of the nursing staff and others involved directly with patients (E.g. Ground Staff and others) important as they recall. How did they feel that was?

5. Recall of whether different disciplines worked well together or if there was any conflict of interest between them.

6. What was the relationship between the patients and League of Friends members like? - Early on/Later on?

7. What was the relationship between the professionals in the hospital and league members like? Early on - Later on?

8. Any significant others who had an influence? (E.g. members of the Management Committee, Clergymen etc.) How was this?

9. Work with men/women. What was the level of contact with female/male patients in respect of gender mixing? Early/Late

10. Men or women working together on any tasks? Men/women such as the Matron/Chief Male Nurse having any authority over men/women in the hospital.
11. Recall of any feelings of co-operation or rivalry between different institutions.

12. How did they feel the full time workers of all types in the hospital felt about and reacted to them? - Early on/later?

13. How do they feel the patients in the institutions reacted to them? - Early on/later?

14. Can the subject remember any particular anecdotes?

15. Was the approach different between those detained Informally and Formally (Certified)?

16. Activity on the wards. How it was organised. The sort of activity there was. Did they have any input in this area? If so - what?

17. What do they feel the main areas of impact were?

18. Opinions as to whether these activities were beneficial to the community or not - If so, which parts or all? In what way?

H - Involvement in wider aspects of the hospital security structure.

1. Where they ever involved in any routes for the patients in the making of complaints regarding containment policies or any other issues?

2. Belief as to whether these routes were effective.

3. How important security involving the patients? Early/Late

4. How the subjects were made aware of security issues?

5. How this security was ensured? (E.g., locked doors, observation cards, exercise yards etc.). Early/Late

6. Whether they and other such as Members of the League - Family members of other staff were able to move freely in different parts of the hospital?

7. Were any areas denied to them e.g. by protocol and other methods and if so which and were they informed why?

8. Recall of the main characteristics of the relationship between the patients and staff - At first/As time passed? E.g., Recall of hierarchy in the relationships between staff and staff, patients and staff, patients and patients.

9. Feelings as to whether this was beneficial, benign, harmful or a mixture.

10. Recall of any incidents that the subjects witnessed that they were not happy about. How they dealt with this?

11. Recall of any instances of practice they witnessed or were involved with that they felt were good.

12. How these influenced them?

I - Changes in the hospital

1. Recall of the introduction of major changes effecting treatment and social activity in the hospital (e.g. the "open door policy") and with the world outside.

2. Who or what is recalled as being the main motivating force in introducing them.

3. What part did others from outside, for e.g. The League of Friends play in these changes?

4. Feelings about such changes.

5. Recall of the feelings of other colleagues. Whether they are remembered as being welcomed or resisted or a mixture of both.

6. Memory of the introduction of the 1948 National Health Service.

7. Feelings about this.

8. Recall of the effect of this on the institutions role (If any) and or those working in it.

J - Staff - Work (If recalled)

1. The relationship between the various departments in the hospital and what it was like.

2. Members of the same families working in the hospital.

3. How new members coming into the hospital were treated.

4. Other nationalities minorities or any identifiable group at the hospital? The tendency to work together or socialise together?

5. The activities, work and social life of the hospital. The question of self-containment within groups either volunteers or staff.

6. Hospital sponsored social or sporting activities. The participation of men and women in them - separately or together.

7. Members helping each other out in both their work and social lives?

8. Particular friends made in the hospital. How this happened if it did?

9. Recall any incidents of unfairness and unkindness towards others that the subjects wished to talk about?

10. Family life and was it effected by the work put in at the hospital in any way?

11. Religious activity in the life of the hospital or as a motivating influence in the voluntary work.

12. Any recall of catering for religious minorities?

K - Outside Community

1. What is recalled as being the relationship between the institution and the outside community both local and wider - Early on/Later?

2. Were the Doctors/Medical Superintendent influential in any way in respect of the relationship with the community both local and wider?

3. If so in what ways? Can the subject provide particular anecdotes?

L - Labour relations.

1. How any disagreements were dealt with? What was the role of the Medical Superintendent in these?

2. Were there any particular issues that arose in respect of volunteers being given a role within the institution?

3. What were they?

4. Were there any demarcation disagreements?

5. How they themselves got along with hospital supervisors, managers and other staff personally.

M - Conclusion

1. What would they wish recall as the major influences on and contributions of, the Nursing/Medical/O.T. Staff/Senior/Junior and other staff of St Crispin Hospital in the changes leading to current Care in the Community.

2. Any other issues the subjects wishes to talk about and topics they wished to expand on.

N - Copyright.

The issue of copyright will have been determined in discussion on the signing of a consent form if agreed by the interviewee. Mention: A transcript of the interview will be presented for scrutiny.

APPENDIX FOUR: The financial and social impact on St Crispin Hospital of the founding of the NHS.

Courtesy of Mr. F. Callow: Copied from a booklet printed to mark the decoration of St Crispin Hospital Chapel with murals.

ST. CRISPIN HOSPITAL
DUSTON, NORTHAMPTON

Hospital was opened 30th June 1876 for 540 at a cost of £162,176 14s. 7d. including cost of land, erection and furnishing, and governed by a Committee of Visitors appointed by the Court of Quarter Sessions. An additional 230 beds were added by 1888 making a total of 770.

On the passing of the Lunacy Act, 1890, the Hospital was governed by a Committee of Visitors appointed by the Northamptonshire County Council.

Between 1890 and 1914 an additional 50 beds were added together with a small Isolation Hospital and a new Laundry.

The Hospital was evacuated during the First World War and used as a Military Hospital.

Between the Wars the Pendered, a modern admission unit *(1935)* for 70 patients and the Nurses Home (1936) with 80 beds, were opened.

During the Second World War over 350 patients were received from other Regions causing a considerable amount of overcrowding which has not yet been alleviated.

On 5th July, 1948, the control of the hospital passed to the Minister of Health under a Hospital Management Committee appointed by the Oxford Regional Hospital Board. Since this date the following major projects have been carried out:

New Bakehouse; New Male Messroom; New hutted accommodation for male and female Occupational Therapy; Library facilities provided under a qualified Librarian; Approved Preliminary Training School under a qualified Tutor; External repairs and internal re-decoration of the Church; Provision of baths and hot water to the Female Convalescent Home; Insulin Treatment Unit; Hairdressing Establishment; Replanting of Hospital Drive with flowering shrubs; together with a considerable amount of re-decoration.

In 1952 a League of Friends was launched, since when the patients have received a considerable benefit in entertainment and friendship—their object: "Promoting the Welfare of the Patients by Voluntary Help."

F.J.C.

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